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ABSTRACT

This volume focuses on therapeutic recreation, as a subject of inquiry and as a treatment tool. The 11 articles include original field based research, program development initiatives, issue and theory of practice papers, and original tutorials in assessment and research. The article titles are: "The Role of Leisure Education with Family Caregivers of Persons with Alzheimer's Disease and Related Disorders" (M. J. Keller, S. Hughes); "Selected Assessment Resources: A Review of Instruments and References" (N. Stumbo); "The Family Lab: An Interdisciplinary Family Leisure Education Program" (M. Malkin, R. Phillips, J. Chumbler); "Perception of Client Needs in Chemical Dependency Treatment Programs" (C. Hood); "Caregivers, the Hidden Victims: Easing Caregiver's Burden through Recreation and Leisure Services" (L. Bedini, C. W. Bilbro); "Facilitating the Child's Adjustment to Parental Disability" (R. Blesch-Hill, L. Heeney); "The Interface between Social and Clinical Psychology: Implications for Therapeutic Recreation" (D. Austin); "Relationships between Meanings of Work and Meanings of Leisure among Wheelchair (Basketball) Athletes" (S. Hunt); "Answering Questions about Therapeutic Recreation Part 1: Formulating Research Questions" (B. McCormick, D. Scott, J. Dattilo); "Answering Questions about Therapeutic Recreation Part 2: Choosing Research Methods" (J. Dattilo, B. McCormick, D. Scott); and "Standards: A Tool for Accountability, the CARF Process" (A. Toppel, B. Beach, L. Hutchinson-Troyer). (IAH)

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Volume Two, 1991

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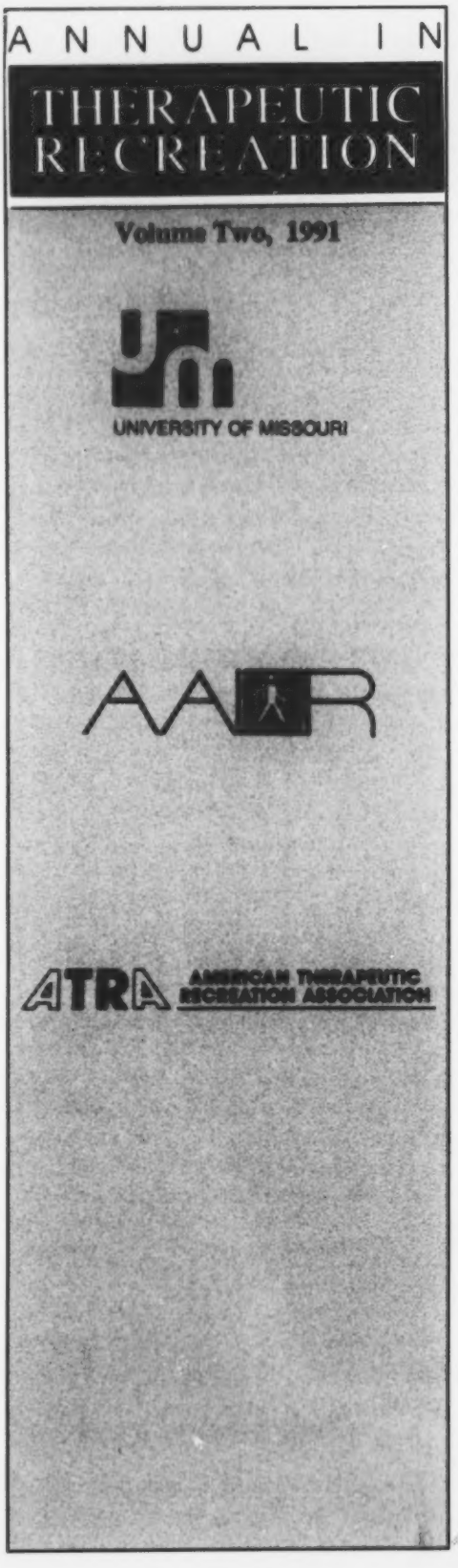

The Annual is a joint venture of the American Association for Leisure and Recreation, The American Therapeutic Recreation Association, and the University of Missouri-Columbia Department of Parks, Recreation and Tourism.

The Department of Parks, Recreation and Tourism at the University of Missouri-Columbia is one of the largest departments in the midwest. The department has a rich tradition of providing quality undergraduate and graduate education. The department hosts numerous workshops, seminars, institutes, and conferences, and coordinates the largest continuing education program in therapeutic recreation in the nation. For more information write: Department of Parks, Recreation and Tourism, 624 Old Clark Hall, University of Missouri-Columbia, Columbia, MO 65211.

The American Association for Leisure and Recreation is a voluntary professional organization dedicated to the development of school and community programs of leisure services and recreation education. It is one of six associations making up the American Alliance for Health, Physical Education, Recreation and Dance. For more information write: AALR, 1900 Association Drive, Reston, VA 22091.

The American Therapeutic Recreation Association was founded in 1984 to advance the profession of Therapeutic Recreation. ATRA is a nonprofit professional organization with a priority focus of promoting the needs of therapeutic recreation professionals in health care and human services settings. For more information write: ATRA, P.O. Box 15215, Hattiesburg, MS 39402-5215.

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Special Tribute

In 1989, the University of Missouri, Department of Parks, Recreation and Tourism presented to the American Association for Leisure and Recreation (AALR) a proposal for the establishment of an annual publication in therapeutic recreation. AALR, under the leadership of then Executive Director Dr. Barbara Sampson, recognized the significant contributions such a publication could make to the profession of therapeutic recreation and thus entered into a joint agreement with the Department of Parks, Recreation adn Tourism at the University of Missouri and also contracted with the American Therapeutic Recreation Association (ATRA) to launch such a publication. Under the terms of the agreement, AALR was to be the publisher, the University of Missouri would serve as editor for the first several years, and ATRA would purchase the publication as a membership journal. This provided a unique opportunity for two national professional associations and a university to work together cooperatively.

Thus, upon successful production of the second volume of *The Annual In Therapeutic Recreation*, AALR and ATRA wish to acknowledge the contributions of the Department of Parks, Recreation and Tourism of the University of Missouri and to thank Drs. Michael Crawford and Jaclyn Card for their benefactions as editors.

Foreword

We are pleased to present in this second volume of the *Annual* articles representing original field based research, program development initiatives, issue and theory of practice papers, and original tutorials in assessment and research. The breadth and depth of work in Volume Two is a fitting testimony to the growth of therapeutic recreation as a discipline and professional therapy. One new editorial feature of the second volume is an invited work. Each year the *Annual*'s editorial board will solicit a select number of original manuscripts to ensure that issues of timely importance are developed and placed before the *Annual*'s readership. Your ideas and thoughts related to invited works are welcome, and we encourage you to communicate with the *Annual*'s editorial board on this new feature of the *Annual*.

This second volume of the *Annual* also represents the concluding volume for the University of Missouri's editorship. Several years ago the UMC Department of Parks, Recreation and Tourism faculty agreed to pursue an exciting new venture—the birth of a professional journal dedicated to the therapeutic recreation profession. Our goal was to create a unique vehicle which would serve as a catalyst in assisting researchers and practitioners to work together toward our common goal of validating the therapeutic recreation process across all its varied constituencies and service settings. Toward that end a unique editorial mission was developed to encourage and promote communication between and among researchers and practitioners by providing for a focus on clinical and community based program development and research.

We feel fortunate to have been able to assemble and work with what is one of the finest associate editor review boards in recreation and leisure literature. The unselfish energy, enthusiasm, and high quality of review work that our associate editors have contributed to the *Annual* has made our collective experience as editors a positive and enjoyable growth experience. Our associate editors are to be congratulated for their efforts in extending formative critical reviews of contributors' works. Through their collective talents the *Annual* has established a high standard of editorial excellence.

We wish to give a special thanks and recognition to our style and production editor, Ms. Paula Belyea. Ms. Belyea's creative talents in layout and design in conjunction with her seemingly endless devotion to production detail are responsible for the *Annual*'s "look." Ms. Belyea has surely been the "heart" of the *Annual*.

As we stated in our inaugural foreword, "we believe that the vitality of a profession is measured by the excellence of its research and literature." We have been pleased to be able to present Volumes One and Two of the *Annual in Therapeutic Recreation* to the profession and we hope that the *Annual* has and will continue to be a measure of the quality that exists within the field. To our partners in this venture, AALR and ATRA, we wish continued professional success. As their stewardship of the *Annual* continues we trust the editorial mission and product produced will continue to do honor to the field. We have appreciated the opportunity to serve and are pleased to present Volume Two to you at this time.

Michael E. Crawford, Re.D., CTRS
Co-editor

Jaclyn A. Card, Ph.D.
Co-editor

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The Role of Leisure Education with Family Caregivers of Persons with Alzheimer's Disease and Related Disorders

M. Jean Keller, Ed.D., C.T.R.S.
Susan Hughes, M.S.

Abstract

Research and literature have well established that stresses of family caregiving to persons with Alzheimer's disease and related disorders can have negative effects on caregivers' mental, physical, emotional, and social functioning. This article presents the concept of using leisure time as a potential coping resource for family caregivers of persons with Alzheimer's disease and related disorders. Leisure education programs are proposed as possible intervention strategies within caregiver support groups to facilitate leisure involvement. An overview of stresses of caregiving, barriers to caregivers' leisure involvement, leisure participation as a means of coping, and the role of leisure education as a component of family caregiver support groups is introduced. It is suggested that leisure education programs be developed and operationalized by therapeutic recreation specialists using the tenets of leisure awareness, leisure activity skills, leisure resources, and social skills. Each component is considered in relation to the needs, interests, and capabilities of caregivers of persons with Alzheimer's disease and related disorders.

"Caregiving has generated more interest among gerontologists than any other topic (George, 1990, p. 580). With the changing demographic landscape of contemporary society, the number of persons needing both formal and informal caregiving is estimated to double within the next 40 years (Fowles, 1988). Presently, there is an estimated four million older adults with Alzheimer's disease and related disorders and 1,600 support groups serving approximately two million caregivers in the United States (Rutledge, 1990). The demand for care of adults with Alzheimer's disease has and will continue to place tremendous burdens on family members. Sneegas (1988) concluded, "the burden associated with caregiving included deteriorating psychological and physical health of caregivers, limited social contact, and reduced opportunities for leisure activities" (p. 81).

Support groups are being used with increasing frequency to help caregivers cope with stresses of caregiving (Lawton, Brody, & Saperstein, 1989; Toseland & Rossiter, 1989). Most support groups maintain a supportive approach that links educational and therapeutic components. Seven major themes are usually presented during a caregiver support group session: information about care receivers' situations; the groups and its members as a mutual support system; emotional impacts of caregiving; self-care of caregivers; problematic interpersonal relationships; development and use of support systems outside of the group; and home care skills (Toseland & Rossiter, 1989). While a self-care theme may explore personal well-being for caregivers, very little of the literature on support groups addresses the leisure aspect of caregivers' lives. Many caregivers fail to recognize the importance and role leisure could play in their lives. Caregivers tend to withdraw from leisure activities, friends, and community involvement while engaging in caregiving (Sneegas, 1988). Thus, there appears to be a need to explore the role of leisure education in the lives of caregivers of persons with Alzheimer's disease and related disorders.

Dr. Keller is an associate professor and Ms. Hughes is a research associate at the University of North Texas, Denton, Texas.

This article will examine how therapeutic recreation specialists may be able to help caregivers explore and address their leisure-related needs and interests as a means to relieving stress and maintaining personal well-being. Specifically, this article will: (a) discuss caregiving stressors and their effect on caregivers' mental, social, emotional, and physical well-being; (b) explore leisure participation as a means for coping with caregiving; and (c) present a rationale for the role of leisure education in caregiver support groups.

Caregiving Stressors

Providing care for persons with Alzheimer's disease and related disorders can have negative effects on caregivers' physical, psychological, and social functioning. George and Gwyther (1986) compared the well-being of family caregivers of memory-impaired adults to available random samples of community adults to determine the areas of well-being most at risk. The findings revealed, caregivers were more likely to experience problems with mental health, emotional well-being, and social participation. Deimling and Bass (1986) suggested from their research that caring for functionally impaired elders created physical and social stresses in the lives of caregivers. Stresses were created for most caregivers because of limitations in opportunities for social and recreational pursuits. Caregiving transforms the ordinary exchange of assistance among people standing in close relationship to each other to an "extraordinary and unequally distributed burden" (Pearlin, Mullan, Semple, & Skaff, 1990, p. 583).

Sneegas (1988) found that caregivers' leisure involvement was significantly changed when compared to participation prior to assuming caregiver roles. Caregivers reported a decline in home entertaining, traveling, dining out, participating in community organizations and clubs, and walking (Sneegas, 1988). The majority of caregivers indicated that constraints of caregiving reduced their freedom of choice. Freedom of choice has been correlated with leisure well-being and participation, as well as life satisfaction (Kelly, 1982).

Additional research findings cite changes in leisure as problematic to family caregivers. Clark and Rakowski (1983) found that compensating for or recovering personal time was listed as a difficult task faced by family caregivers. Rabins, Mace, & Lucas (1982) reported that 50% of the respondents in their study identified loss of friends and hobbies as burdensome aspects of caregiving. Although leisure involvement is drastically reduced and challenging for family caregivers, it has been shown to be an effective coping technique for some caregivers.

Leisure Participation as a Means to Cope

Coping represents specific behaviors and practices of individuals as they act on their own behalf (Pearlin, 1990). The degree of burden that caregivers perceive depends more on the caregivers' ability to cope than on the degree of severity of patients' impairment (George & Gwyther, 1986; Montenko, 1989; Zarit, Reever, & Bach-Peterson, 1980; Sneegas, 1988; Zarit, Todd, & Zarit, 1986; Zarit & Zarit, 1982). Studies by Sneegas (1988) and Zarit and Zarit (1982) concluded, interventions to improve the coping ability of caregivers may relieve the physical, social , and emotional difficulty that they may be experiencing.

Leisure involvement has been found to facilitate coping behaviors among caregivers of individuals with Alzheimer's disease (Sneegas, 1988). Leisure may be defined as an activity chosen for its own sake (Kelly, 1982). According to Sneegas (1988), leisure involvement provided an escape from caregiving and helped to reduce tension. The findings of Sneegas' (1988) study supported the concept that leisure involvement is a means to enhance the coping ability for caregivers and suggested provisions of specialized leisure services for caregivers of persons with Alzheimer's disease. Another study which investigated the contribution of leisure in adjusting to life transitions indicated nearly 80% of a random sample ($N=120$) reported that leisure had been a resource for them in coping with change (Kelly, Steinkamp, & Kelly, 1986). This same study also revealed that 44% of the respondents reported leisure had provided a context for maintaining or developing important relationships; over 19% felt leisure allowed an escape from problems, and an additional 12% said, leisure participation led to personal expression and satisfaction. This research indicates the importance of leisure for caregivers' well-being and the role of leisure involvement as a coping mechanism for controlling the stressors associated

with caregiving. However, caregivers' leisure and self attitudes, awareness, skills, and resources may inhibit them from engaging in meaningful leisure experiences (Pratt, Schmall, & Wright, 1987; Sneegas, 1988; and Zarit & Zarit, 1982).

Caregivers have indicated various barriers to their leisure involvement. Time was a major barrier for not participating in leisure activities according to some caregivers, as caring for family members consumed inordinate amounts of personal time (Pratt et al., 1987; Sneegas, 1988). Repaying what was given may contribute to caregivers' sense of moral obligation to provide care for family members (Pratt et al., 1987). Many caregivers believed that it was wrong to turn the care of their relatives over to someone else or they felt guilty for having to ask others to help (Zarit & Zarit, 1982). Several studies provide evidence that many caregivers have expressed concern with their own needs as selfish and guilt-provoking (Brody, 1985; Hooyman & Lustbader, 1986; Pratt et al., 1987). However, other studies reveal that it is essential to impress upon caregivers the importance of taking care of themselves in order to continue to provide quality and appropriate care to impaired family members (Pearlin et al., 1990; Zarit & Zarit, 1982). A potential means of addressing caregivers' barriers to leisure participation is through structured leisure education programs within family caregiver support groups.

Leisure Education Programs

The potential of leisure as a coping resource provides a clear rationale for the development and implementation of leisure education programs for caregivers of persons with Alzheimer's disease and related disorders. Peterson and Gunn (1984) stated that the purpose of leisure education was to provide opportunities for acquiring skills, knowledge, and attitudes related to leisure involvement. A leisure education program designed for family caregiver support groups could be beneficial to caregivers in several ways: (a) to help caregivers balance their time and responsibility for care of patients and themselves; (b) to help caregivers adjust to changes and constraints caregiving places on their leisure involvement; and (c) to assist caregivers in identifying personal, family, and community resources that could enable them to engage in meaningful leisure experiences while providing care.

A leisure education program could assist caregivers in utilizing leisure as a coping resource. A major objective for a leisure education program would be to assist each caregiver in the development of a personalized plan of action and identification of necessary resources for implementation of the plan (Mundy & Odum, 1979; Peterson & Gunn, 1984; Sneegas, 1988). This could be facilitated by therapeutic recreation specialists through a program design that develops awareness, knowledge, skills, and decision making necessary to enable caregivers to understand the role of leisure in their lives and increase opportunities for leisure involvement.

Mundy and Odum (1979) presented a potential scope and sequencing for leisure education under six categories including self-awareness, leisure awareness, attitudes, decision making, social interaction, and leisure skills. Peterson and Gunn (1984) proposed four major components, leisure awareness, leisure activity skills, knowledge and awareness of leisure resources, and social skills, in their leisure education model. A combination of these two models are highlighted for possible use by therapeutic recreation specialists with caregiver support groups.

Leisure Awareness

An important aspect of an active leisure lifestyle appears to be an awareness of leisure and its benefits, a valuing of leisure experiences, and the conscious decision making process to engage in leisure activities (Keller, McCombs, Pilgrim, & Booth, 1987; Mundy & Odum, 1979; and Peterson & Gunn, 1984). The leisure education program content emphasizing leisure awareness may include information on the value and potential benefits of leisure related to caregivers' roles. During this phase of a leisure education program, caregivers are also challenged to explore leisure attitudes and discuss skills needed for decision making and planning leisure involvement. A focus of this step in a leisure education program would be to assist caregivers in assessing how they expended their time before being a caregiver, how their time is expended now; and what leisure meant to them prior to caregiving and what it means to them now. Exercises presented in a manual entitled, *Helping Older Adults Develop Active Leisure Lifestyles*, could be adapted and utilized for this phase. Exercise one consists of a time diary or a record of daily activities which could provide caregivers with insight into what

they are presently doing with their time (Keller et al., 1987). Caregivers may be surprised, with the help of therapeutic recreation specialists, to discover time perceived as occupied with caregiving tasks, may not be as engaged or could be allocated in a different manner. Caregivers will initially need a sound understanding of the time available to them in order to view leisure involvement as feasible within their lives.

Brody, Saperstein, & Lawton (1989) using case studies explored the use of a multi- service respite program for caregivers of Alzheimer's patients and caregivers initial reluctance to utilize support services. It was discovered that an elderly spouse suffering from multiple health problems and exhaustion from caring for her demented husband, reluctantly agreed to try day care for her husband's well-being. Respite care services proved to be as beneficial for the wife as her husband because she was able to rest, relax and engage in meaningful leisure experiences which she no longer thought were options for her.

Some caregivers may be unable to personally integrate leisure into their lives if there is not an established balance between self and care of family members. Brody et al. (1989) reported that many caregivers needed assistance in recognizing that "they too had needs that differed from the needs of the patient" (p. 49). These problems were compounded by the fact that some caregivers had no outside interests. These findings support a need for a leisure education component that explores leisure awareness within a support group context.

Leisure Activity Skills

Based on the findings of Brody et al., (1989) another component of a leisure education program for caregivers may be knowledge of leisure activities and skill development. The content of this phase of a leisure education program may consider new leisure interests or modifying former ones. Therapeutic recreation specialists could assist caregivers in exploring leisure activities they enjoyed and found satisfying prior to caring for family members. Additionally, therapeutic recreation specialists may examine with caregivers leisure activities they presently enjoy which could be adapted so the activity could be engaged in with impaired family members. Caregivers may likewise explore leisure activities that they find satisfying that could be participated in with other family members, friends, or alone. This may include exploring traditional and non-traditional leisure pursuits. Therapeutic recreation specialists may help a caregiver identify reading to a family member as a potential leisure activity, if the caregiver enjoyed reading in the past, yet, no longer felt there was time to read; or walking with the patient may be proposed, if walking elicited feelings of satisfaction for the caregiver. Examples of non-traditional activities are stress management, relaxation techniques, meditation, and bio-feedback (Sneegas, 1988) which could be introduced by therapeutic recreation specialists to caregivers. Brody et al. (1989, p. 55) provided the following case that illustrates a caregiver who was unable to identify her own leisure interests and pursue them without assistance.

"Mrs. K. had been caring for her severely demented husband for more than six years. The only other family member lived 1,500 miles away. Mrs. K. never went out of the home and the social worker was able to identify only one interest: cooking. After much case work, the worker struck a bargain with Mrs. K. She would allow her to teach the worker how to cook an ethnic dessert, if at the time of the lesson, an aide could be brought in to watch Mr. K. The successful outcome was that the worker then was able to involve Mrs. K. in a cooking class in a local community center's senior citizen group." A leisure education program would need to focus on helping caregivers discover their own separate needs and interests and assisting them in identifying and developing activity skills.

Knowledge and Awareness of Leisure Resources

Montgomery and Borgatta (1989) found from a study of family caregivers, that these families are fiercely independent and have little contact with formal service providers. However, caregivers' ability to engage in leisure involvement will depend heavily on their knowledge and awareness of support services and leisure resources (Sneegas, 1988; Zarit & Zarit, 1982). This third phase of a leisure education program is important for caregivers of persons with Alzheimer's disease or related disorders. Therapeutic recreation specialists should be aware of formal support services available in communities such as respite care (e.g., in-home, day, evening, and institutional care). Caregivers may also need help in investigating their own personal and family resources

(relatives, friends, neighbors, and finances) which could help them create meaningful leisure opportunities for themselves. With knowledge of respite services, caregivers may be more willing to explore leisure resources for themselves. Haley (1989) found that caregivers, from lower income levels who wanted to participate in support services to assist them in coping with the stressors of caregiving, were not able to do so due to unavailability of sitters and transportation. Caregivers also were found to have limited knowledge of leisure resources in their communities and how to access them (Sneegas, 1988). Therapeutic recreation specialists may be challenged to work with caregivers to overcome leisure involvement barriers by identifying and utilizing a wide variety of resources.

Caregivers in this phase of a leisure education program may be exploring new and different leisure pursuits due to the responsibilities of providing care for family members. Thus, caregivers may need additional support in locating appropriate leisure equipment, facilities, and activities. Therapeutic recreation specialists should maintain up to date resource files to help caregivers locate community resources and make suitable referrals.

Social Skills

The last stage of a leisure education program with caregivers involves the development of social skills. Sneegas (1988) recommended potential areas of focus may be helping caregivers increase their abilities to ask for assistance, accept offers of assistance, and assert themselves related to their personal needs. Many caregivers do no have these skills or fail to exercise them due to various reasons. Caregivers may refuse help because they feel a deep sense of responsibility to the people for whom they are providing care (Brody et al., 1989). Caregivers often have strong needs for repaying what was given to them (Pratt et al., 1987). An example of caregiving highlighted by Brody et al. (1989) demonstrates the need for a caregiver to socialize and her inability to experience it. A daughter caring for her mother was initially reluctant to use respite services; however, four hours of in-home respite were scheduled so that the daughter could attend a social event. The daughter's first respite experience was upsetting because the respite worker was late. As a result, the daughter had difficulty enjoying her leisure time because she constantly worried about her mother's care. The guilt over relinquishing caregiving responsibilities may inhibit many caregivers from integrating leisure into their life unless they have the opportunity to process feelings and develop appropriate social skills. Brody et al. (1989) also found that many caregivers were unable to use respite care until they were helped to express their anxieties, fears, and negative feelings about the patients. Caregivers may need reassurance from professionals and support groups members that their feelings are natural, real, acceptable, and experienced by other caregivers (Brody et al., 1989). It appears that therapeutic recreation specialists may need to process with caregivers their feelings in order to help them obtain the social skills needed to engage in meaningful leisure involvement.

Therapeutic recreation specialists may offer opportunities for assertiveness training; sharing of feelings in a supportive, yet, confrontational environment; and leisure counseling as aspects of leisure education in order to help caregivers develop social skills which will facilitate meaningful leisure involvement. For instance, many family caregivers were found to be older, isolated women who had been caring for their husbands for many years. According to Brody et al. (1989), "it was difficult for them to grasp the concept that the instrumental tasks of caregiving were not inextricably bound to the love and support they provided and the former could be accomplished (even if not as well), by others" (p. 55). This example affirms a need for a leisure education program component which promotes and develops appropriate social skills to empower caregivers to use leisure time as a means of coping and enhancement of personal well-being.

Conclusions

Research and literature have well established that stresses of family caregiving to persons with Alzheimer's disease and related disorders can have negative effects on caregivers' mental, physical, emotional, and social functioning. Support groups are increasingly being used as a means to help family caregivers cope with the stresses of caregiving. Interestingly, support groups cover a wide range of topics; yet, few have discussed the role of leisure in caregivers' lives. Sneegas' (1988) research findings indicated that leisure involvement was a means of

coping for family caregivers. While leisure education has been used by therapeutic recreation specialists with numerous groups and individuals to facilitate and empower them to use leisure time to enrich and enhance their lives, it has not been readily used in caregiver support groups nor with family caregivers. It appears leisure education programs as part of family caregiver support groups hold promise in helping caregivers "...to better cope with their caregiving responsibilities not the least of which is to provide care and support to themselves" (Greene & Monahan, 1989, p. 477).

Facilitating leisure education programs within support groups may be a new role and responsibility for therapeutic recreation specialists. Toseland, Rossiter, and Labrecque (1989) studied the effectiveness of peer and professionally led caregiver support groups. The results indicated that professionally led groups produced a significantly greater improvement in psychological functioning. Participants in professionally led groups experienced improvement in coping with personal problems, knowledge of community resources, and increased their informal support systems (Toseland et al., 1989). Based on these findings it would appear that qualified therapeutic recreation specialists could best facilitate caregivers awareness about the necessary skills, knowledge, and resources available to implement a personal leisure plan while caring for family members with Alzheimer's disease and related disorders. Through a leisure education program within family caregiver support groups, caregivers of persons with Alzheimer' disease and related disorders may be empowered to develop coping abilities which will foster leisure involvement and in turn overall well-being.

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Selected Assessment Resources: A Review of Instruments and References

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Abstract

Client assessment plays a vital role in planning appropriate intervention strategies and in measuring client outcomes. While its importance has been recognized repeatedly, several problems have detracted from its meaningful use. The problems include: lack of assessment tools in general; limited content, scope and intent of assessment tools; lack of psychometric adequacy of existing tools; lack of specialists' expertise; and lack of availability. The primary intent of this article is to improve upon the fifth problem by providing an overview of 45 assessment tools and supplying relevant references. As more tools are developed, validated and made available, the profession should see an increase in the quality of client assessment procedures.

Dunn (1984, p. 268) defines assessment in therapeutic recreation as "a systematic procedure for gathering select information about an individual for the purpose of making decisions regarding that individual's program or treatment plan." It is the first link in establishing a meaningful baseline of the client's leisure-related interests, abilities, knowledge level and/or attitudes. Only after a complete initial evaluation can the therapeutic recreation specialist begin to design a purposeful plan of activities and treatment for intervention purposes (Dunn, 1984; Stumbo & Rickards, 1986). In this way, client assessment is the foundation for determining the outcomes of therapeutic recreation intervention in that it provides the foundation information for a pre- and post-treatment comparison of client behavior. "The key element...is the ability to accurately assess leisure interests and needs as well as identify leisure deficits and strengths to facilitate freedom, choice, opportunity and intrinsic motivation (Olsson, Shearer & Halberg, 1988, p. 35). As such, client assessment is the mandatory prerequisite to the appropriate provision of therapeutic recreation services (Witt, Connolly & Compton, 1980; Wehman & Schleien, 1980a).

Problems Associated with Client Assessment

Until quite recently, therapeutic recreation sorely lacked quality assessment instruments. Several problems may have contributed to the historical lack of available and appropriate instruments. These problems have been well-documented in the therapeutic recreation literature and are outlined briefly below.

Lack of assessment tools in general. Few assessment instruments have been developed exclusively for use in therapeutic recreation services due to several factors. Among these explanations are the limited definition of therapeutic recreation as a *recreational* or *diversional* program which did not mandate the use of assessment, the lack of the therapeutic recreation specialists' ability to conceptualize a comprehensive program of services

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for the leisure ability approach (Peterson & Gunn, 1984) and the lack of understanding the role client assessment can play in the total programming process. Dunn (1984, p. 270) stated that when confronted with these conditions, therapeutic recreation specialists often inappropriately *borrow* assessments from other disciplines that do not relate to leisure or use assessments that were created for non-disabled populations Also, therapeutic recreation specialists may have created their own assessments at the agency level, without concerning themselves with the validation or refinement of the instrument (Dunn, 1984; Kinney, 1980; Touchstone, 1975). Both of these situations put the validity and reliability of the assessment results in question.

Limited content, scope and intent of assessment tools. Assessment tools of the 1970s and early 1980s consisted almost solely of leisure interest inventories, with an occasional tool developed for determining client skills in specific leisure activities (Witt et al., 1980). The content of these instruments reflected a relatively narrow definition of therapeutic recreation services, heavily weighted toward an *activity* orientation rather than a more encompassing *leisure behavior* focus (Dunn, 1984; Stumbo & Rickards, 1986; Witt et al., 1980). Often viewed from a limited intake purpose, the results may have had little real meaning and may have made a minimal contribution to understanding client behavior. "A frustrating outcome of this misguided use of assessment as measurement is the realization that the results derived from an irrelevant assessment instrument are of little informative value in providing program direction and may totally misdirect program decisions" (Witt et al., 1980, p. 6).

Lack of psychometric adequacy. Closely related to the above concern, the beginning instruments often lacked credibility, standardization, generalizability and other appropriate psychometric qualities, such as validity and reliability (Burlingame & Blaschko, in press, p. 1; Kinney, 1980; Stumbo & Rickards, 1986; Touchstone, 1975). Often, assessment tools or procedures are utilized routinely without great concern for the measurement properties of validity and reliability (Dunn, 1989). These concepts are discussed in greater detail in the following section.

Lack of specialists' expertise. Although the content area of assessment was rated as one of the most important in the national job analysis conducted for the National Council for Therapeutic Recreation Certification (Oltman, Norback & Rosenfeld, 1989), most therapeutic recreation staff do not have adequate knowledge of and/or skills in client assessment (Dunn, 1984). While this scenario may be changing, on the whole it appears to be changing slowly. Professional preparation curricula and continuing education opportunities often do not have adequate time and resources to equip future and current professionals with functional expertise in assessment concepts and procedures.

Lack of availability. Given some of the above considerations, one of the major problems faced by practicing therapeutic recreation professionals is the availability of usable assessment instruments. Past efforts to make assessments available nationally were minimal, and dissemination efforts by professional organizations, publishing companies and the like were unheard of. Assessment instruments were, and sometimes still are, difficult to find. Several shifts in the provision of therapeutic recreation services, including the emphasis on program accountability and the measurement of client outcomes (Olsson et al., 1988), the increasing sophistication of therapeutic recreation specialists, and the increasing number of *cottage industry* publishers, have improved this bleak outlook considerably in the past five years. More and better instruments are being produced and validated, client assessments are conducted more frequently and at a higher level of quality and the availability of instruments is greater than ever.

The above problems documented throughout the literature point to the fact that much work still needs to be undertaken with regard to client assessment. Specialists' skills must be improved, assessment instruments need further testing for validity and reliability and information about assessment must continue to be shared. It is the purpose of this article to provide an overview of assessment information and to review a selected number of assessment tools as well as to provide information on their intended purpose, availability and documentation. Prior to this review, the next section will outline the measurement concerns of validity, reliability and usability.

Measurement Characteristics

The job of the specialists is to select the best, most appropriate and useful assessment instruments and procedures to fit the purposes of the program and the needs of the client (Stumbo & Thompson, 1985). To

perform this task, the specialist must become familiar with the measurement characteristics of assessment instruments. The three relevant concepts here are validity, reliability and usability. Because these concepts have been covered in-depth elsewhere in the therapeutic recreation literature (cf., Dunn, 1984, 1989), the discussion will be limited to a brief summary.

Validity "refers to the extent to which the results of an evaluation procedure serve the particular uses for which they are intended" (Gronlund, 1981, p. 65). It describes how well the assessment results match their intended purpose; whether it is measuring what the user thinks it is measuring. Three types of validity exist: content, criterion-related and construct validity. Briefly, *content validity* is the degree to which the use "is able to show that the questions and problems on the test are representative of a specified content domain that the test items sample" (Shimberg, 1981, p. 1143). Content validity asks the question of how representative the assessment is to the overall concept (e.g. leisure behavior) it is supposed to be measuring. *Criterion-related validity* concerns the inferences made from a person's assessment results in relation to some other variable called an outside criterion. Typical criterions in therapeutic recreation might include leisure participation after discharge, community living skills and the like (assuming a correlation between the assessment, the intervention and the post-discharge measurement). Construct validity, as the third validation strategy, is used when an unobservable *trait* is being measured to assure that it is being measured adequately. Constructs in therapeutic recreation may include leisure satisfaction, perceived freedom, etc.

Reliability refers to the accuracy or consistency of the assessment results. Reliability can be indicated in three ways: stability measures (how stable is the instrument over time?); equivalency measures (how closely correlated are two or more forms of the same assessment?); and internal consistency measures (how closely are items on the assessment related?). The type(s) of reliability tested on an assessment depends upon the nature of the information needed and the purpose and intended use of the instrument.

Usability is a non-statistical concept that is concerned with the practicality of the assessment. Typical usability concerns include availability, cost, time for administration, scoring and interpretation and amount of staff expertise needed.

To help the reader apply these concepts, the next section discusses the process and questions used in selecting an assessment instrument or procedure. This information is provided so that the user can more readily select an appropriate assessment from the resources at the end of this article.

Selection and Use of Assessment Instruments

The selection and utilization of valid, reliable and practical assessments is vital to the provision of therapeutic recreation programs that are based on client need and have the ability to affect and measure client outcomes. Other sources (cf., Dunn, 1983, 1984, 1989; Stumbo & Rickards, 1986) have documented processes and questions to be answered during the instrument selection stage.

Dunn (1984) outlined a six-step process which includes: (a) determining the purpose of the program and the intended purpose of the assessment; (b) specifying the content or areas that the assessment should cover; (c) identifying other selection criteria (e.g. , validity and reliability); (d) searching and reviewing available assessment resources; (e) comparing assessments against criteria identified in steps b, c and d; and (f) selecting the assessment that best fits the criteria. Stumbo and Rickards (1986) identified four major categories of criteria to be used in the selection process: (a) program, (b) population, (c) staff, and (d) administrative concerns. Under each of these four headings, the assessment user is asked to respond to questions which address validity, reliability and usability concerns. Dunn (1989) provided 19 guidelines for the selection, administration, scoring and reporting of assessment procedures and for protecting clients' rights. Examples of these guidelines include: "The assessment should provide evidence of validity" (p. 60) and "The manual and test materials should be complete and of appropriate quality" (p. 65). Detailed information is given under each guideline.

During the selection process, the specialist should review articles such as the ones mentioned above and become familiar with the systematic process which should be used. Not using such a process can greatly decrease the validity, reliability and usefulness of an assessment tool or procedure. Since the selection process is *generic*, in that the same process can be used to evaluate a variety of assessment tools, once familiarity is gained, the process can be used

repeatedly. Its use is suggested in reviewing the resources given in a later section of this article.

Types of Assessment Instruments Reviewed

One of the major purposes of this article was to provide therapeutic recreation specialists with current information concerning available assessment resources. Connolly (1981), Howe (1984), Stumbo and Thompson (1985) and Wehman and Schleien (1980b) also provided such resources, although each of these was more narrow in scope and are becoming dated due to the more recent activity in assessment development and publication.

To meet the article's intended purpose, information about 45 assessment tools is presented in table format, followed by relevant literature references. Publisher information is also given to aid the user in locating and purchasing instruments. Availability, diversity and potential usefulness to therapeutic recreation practice were the two main criteria for inclusion. It is acknowledged that other potentially useful assessments may have been overlooked and this is not to detract from their use. It is also acknowledged that, due to space limitations and sometimes the lack of complete documentation, the description given for each tool is brief. It was not the intention of the author to provide in-depth information or to judge the quality and appropriateness of each instrument , as it is felt that this becomes the responsibility of the user.

For the purposes of this discussion, the 45 reviewed client assessment tools have been categorized under four major sub-headings. First, are those that measure *Leisure Attitudes and Barriers*. Instruments in this category measure concepts such as perceived leisure competence, perceived leisure control, leisure satisfaction, leisure barriers and leisure attitudes. Twelve instruments were placed within this heading. The second major category includes those tools which measure *Functional Abilities*, such as motor, cognitive and social interaction skills and developmental levels. Nineteen tools were categorized within Functional Abilities. The third division includes three instruments which measure specific *Leisure Activity Skills* in hiking, downhill skiing and cross country skiing. The fourth category contains eleven instruments which examine *Leisure Interests and Participation Patterns*. Typically, these instruments examine the client's past, present or anticipated leisure behavior.

It should be noted here that several instruments sample from more than one of the categories listed above. Some combine leisure attitudes and participation patterns, others combine leisure interests and functional abilities. These types of assessments were created to reflect a multi-pronged programming approach and often defied simple categorization. However, they have been categorized by what appears to be their major emphasis in content and their similarity to other instruments within a particular section.

Following the section on assessment instruments is a selected list of references. General and historical references are given as well as references for individual assessments. These may be helpful to those individuals wanting further information concerning the development and intended use of particular tools.

CATEGORY/ASSESSMENT NAME	BRIEF DESCRIPTION	PUBLISHER
LEISURE ATTITUDES & BARRIERS		
1. Leisure Diagnostic Battery (LDB) (Witt & Ellis, 1982)	Assesses client's perceived freedom in leisure and of factors which are potential barriers to this freedom. Composed of eight scales grouped in two sections. Individual scales: Perceived Leisure Competence, Perceived Leisure Control, Leisure Needs, Depth of Involvement, Playfulness, Barriers to Leisure Experiences, Knowledge of Leisure Opportunities and Leisure Preferences. Extensive documentation and information on validity and reliability available. Short forms and long form.	Venture Publishing 1640 Oxford Circle State College, PA 16803 (814) 234-4561
2. Life Satisfaction Scale (LSS) (Lohmann, 1980)	Measures perceived satisfaction with life through 32 items. Can be self-administered by client or given by therapist. No validity and reliability studies reported. May be useful to compare client from one year to next.	Idyll Arbor, Inc. (#109) 25119 S.E. 262 Street Ravensdale, WA 98051
3. Leisure Satisfaction Scale (LSS) (Beard & Ragheb, 1980)	Measures leisure satisfaction through six components: Psychological, Educational, Social, Relaxation, Physiological, and Aesthetic. Twenty-four items are rated on 5-point scale from Almost Never True to Almost Always True (e.g., "My leisure activities are interesting to me." Validity and reliability information available.	Mounir G. Ragheb Leisure Services/Studies College of Education Florida State University Tallahassee, FL 32306
4. Leisure Motivation Scale (LMS) (Beard & Ragheb, 1983)	Measures leisure motivation through four sub-scales: Intellectual, Social, Competence/Mastery and Stimulus/Avoidance. Scale has 48 items (12 in each sub-scale), which are rated on 5-point scale: "Never True" to "Always True." both short and long forms available. Validity and reliability information available.	Mounir G. Ragheb Leisure Services/Studies College of Education Florida State University Tallahassee, FL 32306
5. Leisure Attitude Scale (LAS) (Beard & Ragheb, 1982)	Measures leisure attitudes through three sub-scales: Cognitive (general knowledge about leisure and how it relates to one's life), Affective (feelings toward leisure), and Behavioral (past, present and intended actions). Consists of 36 items rated on a 5-point scale of Strongly Disagree to Strongly Agree. Validity and reliability information available.	Mounir G. Ragheb Leisure Services/Studies College of Education Florida State University Tallahassee, FL 32306
6. Brief Leisure Rating Scale (BLRS) (Ellis & Niles, 1985)	Measures degree of learned helplessness, as completed by an external evaluator familiar with the client. Consists of 25 items rated on 5-point scale. Initial validity and reliability information available.	Gary Ellis Dept. of Rec. & Leisure University of Utah Salt Lake City, UT 84112

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CATEGORY/ASSESSMENT NAME	BRIEF DESCRIPTION	PUBLISHER
7. Comprehensive Leisure Rating Scale (CLEIRS) (Card, Compton & Ellis, 1986)	Designed to measure independence level of older individuals with mental illnesses, contains combination of perceived freedom (28 items), helplessness (25 items), breadth of activity skills (12 items), and depth of activity skills (12 items). Borrows concepts from LDB, BLRS and STILAP assessments. Validity and reliability information available.	Jaclyn Card Dept. of Parks, Rec. & Tourism 624 Clark Hall University of Missouri Columbia, MO 65211 (314) 882-7086
8. Leisure Barriers Inventory (Peterson, 1982)	Examines leisure barriers in eight categories (e.g., Time, Money and Transportation; Leisure Responsibility; Leisure Partners, etc.). Client responds to 48 items on 3-point scale (Agree, Don't Know, Disagree) such as "Leisure is free time" and "I like to do different recreation activities." Score reported for eight sub-categories. Initial validity and reliability information available.	Julie Dunn Dept. of Rec. & Leisure University of North Texas Denton, TX 76203
9. What Am I Doing? (WAID) (Neulinger, 1986)	Measures quality of life through three dimensions: Perceived Freedom (Choice), Intrinsic Motivation (Reason), and Feeling Tone (Feeling). Client completes daily log of activities, then examines degree of choice, reason for engagement and feeling tone of each activity. Validity and reliability indices reported. Forms and manual available.	The Leisure Institute R.D. #1, Hopson Road Box 416 Dolgeville, NY 13329
10. Leisure Well-Being Inventory (McDowell, 1987)	Through yes/no checklist, asks clients to examine leisure attitudes and knowledge. Categories include: Coping, Awareness/Understanding (including influence of work, ability to leisure, and value of leisure) and Knowledge (including interests, resourcefulness, and fitness). Clients encouraged to use score to examine leisure well-being. No validity and reliability information available. Related books also available.	C. Forrest McDowell SunMoon Press P.O. Box 1516 Eugene, OR 97440 (503) 343-9544
11. Perceived Competence Scale for Children / Self-Perception Profile for Children (Harter, 1982/83)	Intended for children 8 to 11 years of age, the scale measures self-perception through six sub-scales: Cognitive Competence, Athletic Competence, Social Acceptance, Physical Appearance, Conduct/Behavior, and General Self-Worth. Each item under the broad categories is responded to on a 4-point scale (roughly from "Really Sounds A Lot Like Me" to "Doesn't Sound At All Like Me." Teachers' Rating forms, manual, validity and reliability information available.	Susan Harter Department of Psychology 2040 South York University of Denver Denver, CO 80208 (Pre-Payment of $9.95 for packet is appreciated.)
12. Over 50 (Edwards, 1988)	Computerized assessment to evaluate the client's personal needs, values and attitudes for better self-understanding, relationships and life/career/leisure planning. Computer aids in analysis and interpretation. User's Manual available. Intended for older clients, may be used with young adults.	Patsy Edwards Constructive Leisure 511 N. La Cienega Blvd. Los Angeles, CA 90048

CATEGORY/ASSESSMENT NAME	BRIEF DESCRIPTION	PUBLISHER
FUNCTIONAL ABILITIES		
13. Functional Assessment of Characteristics for Therapeutic Recreation (FACTR) (Peterson, Dunn & Carruthers, 1983)	Examines functional skills and behaviors considered to be prerequisite to leisure involvement. Eleven behaviors are in each of three categories: Physical, Cognitive and Social/Emotional. Sub-categories are to be rated on 3 or 4-point scales after observation by therapist. Some reliability studies reported. Usable for any special population.	Idyll Arbor, Inc. (#113) 25119 S.E. 262 Street Ravensdale, WA 98051 (206) 432-3231
14. Ohio Leisure Skills Scales on Normal Functioning (OLSSON) (Olsson, 1988)	Measures twenty functional abilities in three major areas: Functional Skills, Behavioral Skills and Social/Communication Skills. Intended for clients with cognitive impairments. Therapist implements five activities in which the client is observed and assessed, then summarizes observations in two sections of instrument. Validity and reliability information available. Assessment kit includes supplies, manual and forms.	Roy Olsson Dept. of HPHP Health Education Bldg. University of Toledo 2801 W. Bancroft Toledo, OH 43606
15. Comprehensive Evaluation in Recreation Therapy - Physical Disabilities (CERT) - Phys. Dis.) (Parker, 1977)	Measures 50 behaviors in eight categories: Gross Motor Function, Fine Movement, Locomotion, Motor Skills, Sensory, Cognition, Communication and Behavior. Uses 5-point observation checklist to be used by therapists in PMR settings for initial and ongoing assessments. Initial validity and reliability studies reported.	Idyll Arbor, Inc. (#121) 25119 S.E. 262 Street Ravensdale, WA 98051 (205) 432-3231
16. Comprehensive Evaluation in Recreation Therapy - Psychiatric/Behavioral (CERT-Psych.) (Parker, 1977)	Measures 25 behaviors required in variety of leisure activities, including General, Individual and Group behaviors. Uses 5-point observation checklist to be used by therapists in psychiatric settings for initial and ongoing assessments. Validity and reliability studies in progress.	Idyll Arbor, Inc. (#116) 25119 S.E. 262 Street Ravensdale, WA 98051 (205) 432-3231
17. Maladapted Social Functioning Scale for Therapeutic Recreation Programming (MASF) (Idyll Arbor, Inc., 1988)	Adapted from the Brief Psychiatric Rating Scale, the instrument examines 21 problematic behavior(s) (e.g., Hostility, Disorientation, Suicidal Preoccupation, etc.) Behaviors are rated on a 7-point scale, from Not Present to Extremely Severe, based on observational descriptions No validity and reliability information available.	Idyll Arbor, Inc. (#117) 25119 S.E. 262 Street Ravensdale, WA 98051 (205) 432-3231
18. Therapeutic Recreation Index (TRI) (Faulkner, 1987	Designed for adolescents/adults in substance abuse, rehabilitation and intermediate care facilities, instrument comes in three "forms" with different questions. Each setting has ten different areas to be assessed (e.g., economic, problem solving, leisure skills). Items rated on 5-point scale that is then weighted for importance to leisure involvement. No validity and reliability information available. Paper and computerized versions.	Rozanne W. Faulkner Leisure Enrichment Services P.O. Box 1190 Seaside, OR 97138

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CATEGORY/ASSESSMENT NAME	BRIEF DESCRIPTION	PUBLISHER
19. General Recreation Screening Tool (GRST) (Burlingame, 1988)	Measures functional abilities in three areas (Physical, Cognitive and Affective) according to developmental age groups up to ten years. Intended for individual with developmental disabilities and is designed for scoring after therapist observation. No validity and reliability information reported.	Idyll Arbor, Inc. (#111) 25119 S.E. 262 Street Ravensdale, WA 98051 (205) 432-3231
20. Recreation Early Development Screening Tool (REDS) (Burlingame, 1988)	Assesses developmental level of client functioning at or below one year of age. Leisure-related areas include: Play, Fine Motor, Gross Motor, Sensory, Social/Cognition, which are detailed by descriptive checklist. Completed through graphed observations of play activities by therapist. No validity and reliability information available.	Idyll Arbor, Inc. (#112) 25119 S.E. 262 Street Ravensdale, WA 98051 (205) 432-3231
21. Fox Activity Therapy Social Skills Baseline (Patterson, 1977)	Developed for use with people who are severely/profoundly mentally disabled, the instrument covers six basic areas of social skills (e.g., Reaction to Others). Each area of social skills is divided into six to levels of social skills to provide baseline and then monitoring of client progress. Primarily conducted through therapist observation. Validity and reliability studies in progress.	Idyll Arbor, Inc. (#106) 25119 S.E. 262 Street Ravensdale, WA 98051 (205) 432-3231
22. Mundy Recreation Inventory for the Trainable Mentally Retarded (Mundy, 1966)	Assesses client's performance and abilities, as well as concepts related to recreation participation (e.g., motor skills, rhythm, manipulation skills, color concepts, etc.) Client asked to perform various tasks while therapist administers assessment. Validity and reliability information available in manual. Manual includes program planning information.	Jean Mundy Leisure Services/Studies 215 Stone Building Florida State University Tallahassee, FL 32306
23. Recreation Behavior Inventory (RBI) (Berryman & Lefebvre, 1981)	Observational tool to assess cognitive, sensory and perceptual motor skills as prerequisites to leisure participation. Eighty-seven behaviors are to be observed during 20 recreation activities, then rated on 3-point scale. Intended for children, but use reported for psychiatric and long term care. Manual and validity and reliability information available.	Doris Berryman Dept. of RLPES 239 Greene St. Room 635 New York University New York, NY 10003
24. Bruninks-Oseretsky Test of Motor Proficiency (Bruninks & Oseretsky, 1972)	Designed for adolescents, instrument measures motor skills. Scale includes four subscales on gross motor, three on fine motor and one combining both gross and fine. Both long and short forms available. Equipment, supplies, manual and validity and reliability information available.	American Guidance Services Circle Pines, MN 55014
25. Idyll Arbor Reality Orientation Assessment (Idyll Arbor, Inc., 1989)	Measures client's orientation to reality, through a section on Screening Questions (e.g., "Professional baseball is played during what season?") and Observational Checklist (e.g., Appearance, Body Posture, etc.). Assessment includes both interview and observation completed in about 20-30 minutes. No validity and reliability information available.	Idyll Arbor, Inc. (#125) 25119 S.E. 262 Street Ravensdale, WA 98051 (206) 432-3231

CATEGORY/ASSESSMENT NAME	BRIEF DESCRIPTION	PUBLISHER
26. Idyll Arbor Activity Assessment (Burlingame, 1989)	Intended for use in long term care facilities, instrument includes: Demographic Information, Leisure Interests and Leisure History, Individual Performance and Social Strengths, and Maladaptive Behaviors. Relying primarily on a checklist format, instrument has space for three separate administrations. Extensive directions. No validity and reliability information available.	Idyll Arbor, Inc. (#124) 25119 S.E. 262 Street Ravensdale, WA 98051 (206) 432-3231
27. Activity Therapy (AT) Assessment (Perschbacher, 1988)	Designed for long term care residents, two page assessment contains sections on: Resident Profile, Lifestyle and Related Abilities and Activity Pursuits, Supports Systems, Psychosocial and Cognitive Functioning, and Primary Strengths and Weaknesses. Requires primarily open-ended notes. Other forms (e.g., Progress Note) and activities manual are available. No validity and reliability information available.	Ruth Perschbacher Bristlecone Consulting Rt. #2, Box 458 Asheville, NC 28805 (704) 298-7357
28. The Bond-Howard Assessment on Neglect in Recreation Therapy (BANRT) (Bond-Howard, 1990)	Measures density and scope of visual neglect for clients with Right CVA who demonstrate left side neglect. "Bull's eye" type target face is used to have client locate appropriate numbers and throw dart as therapist times reactions and correctness of information. Score sheets include Daily Score Sheet #135 (for recording answers), and #136 for assessing density and scope. No validity and reliability information available.	Ptarmigan West 1061 Josh Wilson Road Mt. Vernon, WA 98273-9619 (206) 428-9785
29. BUS Utilization Assessment (Burlingame, 1989)	Checklist used to determine client's performance and understanding of using public buses as transportation. Surveys both functional skills and maladaptive behaviors in detailed checklist format, resulting in accurate picture of ability to independently function. Intended for individuals with mental retardation or cognitive impairments. Initial validity or reliability information available.	Idyll Arbor, Inc. (#126) 25119 S.E. 262 Street Ravensdale, WA 98051 (206) 432-3231
30. Burlingame Software Scale (Burlingame, 1980)	Rating scale for analyzing appropriateness (difficulty) of computer games for people with disabilities; may also be used to assess some functional abilities of the client. Topics include Memory Required, Planning Skills, Scanning, etc. No validity or reliability information available. Individual computer log available to track client use.	Idyll Arbor, Inc. (#131) 25119 S.E. 262 Street Ravensdale, WA 98051 (206) 432-3231
31. Communication Devise Evaluation (Burlingame, 1990)	Measures compatibility of client's augmentative communication device to leisure lifestyle. Used to evaluate individual devices available to the client. Includes several characteristics under six general categories (e.g., Interface Options, Output Options, etc.) and five leisure settings (e.g., Store/Restaurant, Transportation, etc.) in which device may be needed. No validity and reliability information reported.	Idyll Arbor, Inc. (#132) 25119 S.E. 262 Street Ravensdale, WA 98051 (206) 432-3231

CATEGORY/ASSESSMENT NAME	BRIEF DESCRIPTION	PUBLISHER
LEISURE ACTIVITY SKILLS		
32. Functional Hiking Technique (Burlingame, 1979)	Assesses client's ability to demonstrate basic skills necessary to hike independently. Divides hiking skills into five skill levels (e.g., Select Proper Attire, Moving Under Obstacles, Moving Over Obstacles, etc.) under which are several more specific skills. Includes instructional strategies. No validity and reliability information available.	Idyll Arbor, Inc. (#140) 25119 S.E. 262 Street Ravensdale, WA 98051 (206) 432-3231
33. Downhill Skiing Assessment (Peterson, 1990)	In checklist format, assesses clients for placement into appropriate skill classes. Clients are to be assessed in each skill area three times, with scores and observations recorded. Documentation of modification is encouraged. Skill levels range from Beginner to Dynamic Skiing. No validity and reliability information available.	Idyll Arbor, Inc. (#137) 25119 S.E. 262 Street Ravensdale, WA 98051 (206) 432-3231
34. Cross Country Skiing Assessment (Peterson, 1990)	In checklist format, assesses clients for placement into appropriate skill classes. Clients are to be assessed in each skill area three times, with scores and observations recorded. Documentation of modifications is encouraged. No validity and reliability information available.	Idyll Arbor, Inc. (#138) 25119 S.E. 262 Street Ravensdale, WA 98051 (206) 432-3231
LEISURE INTERESTS & PARTICIPATION		
35. Leisurescope/Teenscope (Nall, 1983)	Examines leisure preferences for adults (Leisurescope) and adolescents (Teenscope). Preferences are divided into nine categories (e.g., Games, Music and Art) to which client responds after viewing "collages" (either laminated cards or slides), feeling during activities are also recorded. Validity and reliability studies reported. Supplies and activity file also available.	Leisure Dynamics 10106 Bear Paw Lane Panama City, FL 32404 (904) 681-5462
36. State Technical Institute Assessment Process (STILAP) (Navar, 1980)	Translates preference and involvement in 123 activities into 14 categories of leisure competence or skills. Can be self-administered or completed by therapist. Initial validity and reliability information available. Created for use with adults with physical disabilities.	Idyll Arbor, Inc. (#130) 25119 S.E. 262 Street Ravensdale, WA 98051 (206) 432-3231
37. Influential People Who Have Made an Imprint on My Life (Korb, Azok & Leutenberg, 1989)	Examines both positive and negative influences on one's life through self-examination and group discussion. Nine categories of people are reviewed (e.g., Teachers and Family Members) according to the influence they exerted on the client. Intended for group administration. No validity and reliability information available. Other instruments available from company.	Wellness Reproductions 23945 Mercantile Road Bachwood, OH 44122 1-800-669-9208 FAX 216-831-1355

CATEGORY/ASSESSMENT NAME	BRIEF DESCRIPTION	PUBLISHER
38. Recreation Participation Data Sheet (RPD) (Burlingame, 1987)	Generically analyzes client participation in any activity by examining seven categories (e.g., Initiation, Independence, Satisfaction, etc.). completion of form allows therapist picture of client's leisure behavior. No validity or reliability information available. Also Supplemental Physical Activity available, focusing on heart rate analysis.	Idyll Arbor, Inc. (#108) 25119 S.E. 262 Street Ravensdale, WA 98051 (206) 432-3231
39. Joswiak's Leisure Counseling Assessment (Joswiak, 1979/89)	Three part assessment for individual with developmental disabilities: Client Information Sheet (Personal Leisure Resources, Leisure Preferences, etc.), Participation in Leisure Activity Assessment Sheet (observation concerning self-initiation, structure, independence, etc.) and Enabling Objectives Assessment Sheet (specific objectives client is to attain). Book focuses on program development and implementation. No validity and reliability information available.	Venture Publishing Company 1640 Oxford Circle State College, PA 16803 (814) 234-4561
40. Leisure and Social/Sexual Assessment (Coyne, 1980)	Measures combination of leisure interests, participation, skills and knowledge in three sections: General Demographics, Leisure Participation Patterns, and Sexual Knowledge. Scored on combination of open-ended questions, checklists and rating scales. Interview format. Intended for people with developmental delays. No validity and reliability information available.	Idyll Arbor, Inc. (#110) 25119 S.E. 262 Street Ravensdale, WA 98051 (206) 432-3231
41. Leisure Activities Blank (McKechnie, 1975)	Measures past leisure participation and intentionality of future involvement through 3-point rating scales. Categories of leisure participation include such areas as: Mechanics, Sports, and Slow Living. Past involvement includes six categories; future includes eight. Manual includes instructions and validity and reliability information.	Consulting Psychologists 577 College Avenue Palo Alto, CA 94306
42. Family Leisure Assessment Checklist (FLAC) (Folkerth, 1978)	Assesses leisure interests of families with children who have disabilities. Activities are grouped in to eight major categories, to which the clients respond on a 7-point scale (e.g., from "Do activity presently" to "Inappropriate to handicapping condition.") Families' scores are then culminated on one sheet to assess differences and similarities. No validity and reliability information available.	Jean Folkerth Department of HPER Warner Building Eastern Michigan Univ. Ypsilanti, MI 48197 (313) 487-0090
43. Constructive Leisure Activity Survey #1 (Edwards, 1980)	Examines leisure interests within five broad categories: Physical and Outdoor, Social and Personal Satisfaction, Arts and Craftsmanship, Learning, and General Welfare. Approximately 50 activities (250 total) are given under each heading. Documentation available.	Patsy Edwards Constructive Leisure 511 N. La Cienega blvd. Los Angeles, CA 90048
44. Constructive Leisure Activity Survey #2 (Edwards, 1980)	Examines leisure interests in over 400 leisure activities; also assesses feelings about past, present and future activities, and relationship between work and leisure. Documentation available.	Constructive Leisure 511 N. La Cienega Blvd. Los Angeles, CA 90048

CATEGORY/ASSESSMENT NAME	BRIEF DESCRIPTION	PUBLISHER
45. Leisure Pref (Edwards, 1986)	Computerized interest inventory involving 92 activities. Computer capability to analyze and interpret results. Available in variety of computer formats. User's Manual available.	Constructive Leisure 511 N. La Cienega Blvd. Los Angeles, CA 90048

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The Family Lab: An Interdisciplinary Family Leisure Education Program

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Abstract

The purpose of this article is to describe the theoretical framework and programmatic elements of the *Family Lab*, an interdisciplinary family leisure education program. The Family Lab is a series of scheduled, prescribed activities designed to fulfill diagnostic needs of the clinical staff, and provide instructive and therapeutic benefits to the family. Areas of focus include communication, trust, values clarification, role playing, and enjoyment of leisure activities. This program was designed for families of adolescents in substance abuse treatment. Literature was reviewed in the areas of leisure education and substance abuse, codependency and family dysfunction, and family leisure counseling. The effectiveness of family and activity therapies is reviewed. The leisure assessment of family members, and the coordination of parenting skills classes with family leisure education sessions are discussed. The programmatic elements of the Family Lab, based upon the above theoretical constructs, are presented in outline form.

The national focus on the *War on Drugs* indicates the extent of substance abuse in the United States. The increased number of adolescent alcoholics and drug abusers has become common knowledge (Leo, 1985). Perdue and Rainwater (1984) state that adolescent alcohol use and misuse is a national concern, attracting increased public and scientific attention. These authors completed a study which indicated that because alcohol consumption is an integral part of many adolescent recreational activities, the need exists for leisure counseling in adolescent treatment programs. The National Recreation and Park Association has acknowledged a growing problem and emphasized the need for a substance abuse prevention program targeted at the youth market (National Recreation and Park Association, 1989; Prince, 1990).

The family, and substance abuse, has been the emphasis of public concern since 1980, evidenced by the President's address to the White House Conference on Families (Carter, 1980) emphasizing drugs, alcohol and the younger members of families, and by the attention to alcohol related family problems (Orford & Harwin, 1982; American Psychiatric Association, 1987, p. 174; Steinglass, Bennett, Wolin, & Reiss, 1987). The American Psychiatric Association (*Diagnostic and Statistical Manual Of Mental Disorders*, 3rd ed., revised, 1987) estimates that alcoholism affects approximately 13% of the population at some time in their lives. One out of four children may grow up in families where substance abuse is a major influence (Norton, 1986) and 85% of adolescents diagnosed as chemically dependent will have a family history of substance abuse (Goodwin, 1988).

The abuse of alcohol and other mood altering chemicals disrupts the family system and can cause patterns of codependency to develop (Beattie, 1987; Steinglass et al., 1987). Organizations such as ALANON, AL-ATEEN, and ACOA (Adult Children of Alcoholics) have proliferated due to increased recognition of the lasting effects of substance abuse upon the family as a whole, and upon family members individually.

The importance of the assessment of leisure and lifestyle behavioral changes in the treatment of

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alcoholism is emphasized by recent literature (DiLorenzo, Prue, & Scott, 1987; Ransom, Waishwell, & Griffin, 1987). Leisure for addicted persons often involves drinking, drugging, other destructive uses of leisure time, and accompanying family disruption. Dysfunctional leisure patterns for the user may involve centering all recreational activities around his or her drug of choice, or withdrawal, isolation, and a total lack of participation in previous leisure pursuits (O'Dea-Evans, 1990; W., Anne, 1985). Ranson et al. reviewed a study (Moos, Bromet, Tsu, & Moss, 1979) which indicated that as the alcoholic patient improved, family cohesion and activity-recreational orientation and organization increased. The same families experienced more positive life events.

This article describes the family leisure education component of a family program for adolescents in an inpatient substance abuse treatment program. This program can be adapted for use in an outpatient or community-based setting. The Family Lab program is interdisciplinary, and involves family therapists, family program counselors, mental health technicians, and nurses, in addition to the recreation therapist, or therapeutic recreation specialist. The theoretical basis for this program was developed as a result of an analysis of the various aspects of the dysfunctional family which may contribute to dysfunction in leisure.

Exploration of the Family Lab Program includes a review of the literature related to codependency and related family roles within the family system; leisure needs, benefits, and barriers of the family of a substance abuser; assessment of family leisure interests; and leisure education activities. Evaluation and follow-up procedures are indicated.

Two versions of this program were developed. A four-week rotation of selected sessions was designed for the adult treatment unit as the length of stay averaged 28 days. A longer series of 6-8 sessions was used for the adolescents whose length of stay averaged 8-12 weeks. This paper describes the adolescent program, in which the family leisure education sessions were coordinated with parental education and parenting skills classes. The leisure education sessions were based upon dysfunctional aspects of the codependent family and emphasized communications, parenting styles, values clarification and role playing.

Accepting the Narcotics Anonymous dictum that "a drug is a drug is a drug," the treatment approach described does not separate the adolescent alcoholics from abusers of other chemicals. Clinical experience of the authors in this regard, supported by the literature (Beattie, 1987), indicates that similar dysfunctional patterns, such as enabling and denial, are evident within most families which include a member with an addictive disease be it alcohol or other drug related. Norton (1988) states that little progress can be made in the treatment of adolescent substance abusers "unless the impact and influence of their chemically dependent family system is addressed" (p. 35).

Review of Related Literature

In designing the family leisure education program (The Family Lab), literature was reviewed in the following areas: leisure education and counseling and substance abuse treatment; codependency and family systems theory; family leisure education; parenting training; and the effectiveness of family and activity therapy as treatment modalities.

Leisure Education and Substance Abuse

A review of the literature reveals increased attention to the issues of leisure education or counseling within substance abuse treatment programs. O'Dea-Evans (1990) has developed *LEAP (Leisure Education for Addicted Persons).* This program analyzes leisure participation for substance abusers. Paralleling the Jellinek Curve of the progression of the disease of alcoholism (Steinglass et al., 1987), *LEAP* (O'Dea-Evans & Dugan, cited in O'Dea-Evans, 1990) includes an analysis of the stages of leisure in chemical dependency, indicating the increasing focus upon *using* within all recreational, social, and family activities as the addictive disease progresses. This analysis indicates improvements in leisure interest and function as the recovery process begins. Ransom et al.'s (1987) review of the literature on leisure and alcoholism indicates that alcoholics view leisure negatively. Most studies have focused upon attitude change, but Ransom et al. stress that a behavioral change leading to "functional independence, (managing leisure time without drinking)" (p. 108) is necessary. To that end they propose a leisure counseling program consisting of Assessment, Leisure Lifestyle Analysis, Action

Plans (Intervention), Leisure Profile Assessment, and Program Revision. The focus is upon attitude change with the belief supported within social psychology theory that "attitude shifts act as causal agents in the behavioral change process" (Ransom et al., 1987, p. 110). DiLorenzo, Prue, and Scott (1987) indicate the limitations of currently available leisure assessment procedures. They note the clinically observed relationship of leisure skills to treatment outcome. Citing Moos et al., (1979) these authors suggest that successful leisure experiences may contribute to adjustment and personal happiness. DiLorenzo et al. (1987), note that behavioral change, not merely attitudinal change, should be the focus of leisure counseling. They note the lack of empirical research on the effects or outcomes of leisure counseling programs.

Perdue and Rainwater (1984) stressed the relationship between decreasing levels of social control and increased recreational participation, with increased adolescent alcohol consumption. Mere provision of recreational activities will not decrease consumption. A leisure education program is recommended in order to enhance the social benefits of leisure choices (Hitzhusen, 1977, and Mobily, 1982, both cited in Perdue & Rainwater, 1984). Current theories of alcoholism involve complex and multivariate social and psychological approaches, necessitating comprehensive programs which focus upon all aspects of an individual's lifestyle (Purdue & Rainwater, 1984).

Family Dysfunction and Leisure

Literature in the areas of family dysfunction, codependency, and family therapy was reviewed to determine the relationship between those patterns of family behavior and family leisure dysfunction. Family patterns of alcoholism have been the focus of many studies. Wolin, Bennett, and Noonan (1979, cited in Leland, 1982) found that an alcoholic's disruption of family rituals (holidays, mealtimes, vacations, etc.) was associated with alcohol abuse in the following generation. Leland (1982) reviewed studies indicating that drinking in offspring is related to deficits in parental group maintenance functions and socialization. Zucher found the patterns of alcoholic families to include parental absence, high family tension, emotional distance, and frequent parental alcohol abuse (1979, cited in Leland, 1982).

The family of an alcoholic may be isolated or withdrawn from social contact due to social stigma (Wilson, 1982). Children in alcoholic families are hesitant to develop close peer relationships (Wilson, 1982). When drinking is associated with marital conflict or aggressive behavior, the children may be badly affected (Wilson, 1982). Family and individual social and peer relationships, as well as recreation/leisure and other "family ritual" patterns may be disrupted in the alcoholic family, as indicated by the above studies. Furthermore, there is a high risk that the children may become alcoholics themselves. The risk of children of problem drinkers developing alcohol problems is about 33% (Cotton, 1979, cited in Wilson, 1982).

The concept of "codependency" has been developed to describe the relationships of an addicted individual with family, friends, peers, and co-workers. One definition of a codependent (Beattie, 1987) is a person who has let someone else's behavior affect him or her, and is obsessed with controlling the other person's behavior. The codependent may appear strong, but in fact is dependent upon others to need them. Codependent family members are individuals whose lives had become unmanageable due to living in a close relationship with an alcoholic or addict. The spouse or child or parent of someone who is chemically addicted develops unhealthy patterns of coping with life. Roles within the codependent family may include the chief enabler, the family hero, the clown or scapegoat, and the lost child (Wegscheider-Cruse, 1981). What are some behavioral patterns within these families which may contribute to leisure dysfunction? Codependents have difficulty communicating, trusting, expressing emotions, detaching emotionally or enjoying themselves (Beattie, 1987; Black, 1982; O'Connell, 1986; Woititz, 1983). Codependents frequently blame, threaten, coerce, complain, beg, bribe, manipulate, and lie. They are afraid to express feelings openly. Low self-esteem is evident (Beattie, 1987; Woititz, 1983). Anger and depression are frequently observed. The addict and his/her family may have difficulty with spontaneity, or fun (Beattie, 1987; Woititz, 1983).

Such characteristics led Black to describe the *don't talk, don't trust, don't feel* model in her book *It'll Never Happen To Me*, (1982). This dysfunctional pattern of family interrelationships was used as the

basis for the Family Lab family leisure counseling program. Black describes *family laws* which develop in the alcoholic family. The first of these, *don't talk*, refers to a prohibition toward discussing the real issues, in this case the drinking. Such a prohibition leads to excuse making and a lack of understanding on the part of family members. This also occurs in part due to denial of the actual problem--alcoholism. The second prohibition, *don't trust*, develops because of the lack of confidence, reliance, and faith family members develop due to the erratic behaviors and emotional states of the alcoholic family member. The third prohibition, *don't feel*, develops as part of the denial system of family members. In order to bring some stability and consistency into their lives, family members tend to deny both their perceptions and their feelings about what is happening in the home (Black, 1985, chap. 3). The other concept included in the Family Lab is Whitfield's idea of *The Child Within*, the spontaneous, childlike state which may be repressed by the user or various family members (1989). Other problem areas noted within the literature for codependent families and addicts include difficulty with problem solving, values clarification, clarifying family boundaries, and issues of responsibility and independency (Steinglass, et al., 1987).

Family Leisure Education

There is little precedent within the therapeutic recreation literature for a family leisure education program. Orthner and Herron (1984) note the linkage between leisure problems and family problems. They review literature which indicates the need for family leisure intervention. These authors note the lack of prior serious writings on leisure counseling in family therapy, or on families in leisure counseling. Two subsequent articles specifically address these topics; Monroe's 1987 article entitled *Family Leisure Programming*", concerns a program for children with physical disabilities, and a second by DeSalvatore, (1989) is entitled *Therapeutic Recreators as Family Therapists: Working With Families On a Children's Psychiatric Unit*. Be cautioned in review of the latter article, that the therapeutic recreation specialist is *not* a family therapist, unless he or she has received additional training and certification. However, recreation therapists may participate as members of an interdisciplinary treatment team in a family therapy program. Monroe reviews studies indicating the positive relationship between family leisure involvement and healthy family dynamics. Edwards (1984, cited in Monroe, 1987) recommended family leisure education in order to increase communication, positive feelings, cooperation, and understanding. Program components for Monroe include team referral and assessment, including a family interview exploring areas such as leisure skills, interests, and barriers, of leisure needs. Following assessment, a treatment plan is developed and the program implemented. Evaluation methods which are suggested include: formative program evaluation procedure; and an analysis of client performance on treatment goals and objectives (Monroe, 1987).

Parenting Training

Parenting styles are a focus for the family education sessions attended by parents participating in the family lab program. The basis for these training sessions includes *The Parent's Guide STEP/Teen: Systematic Training For Effective Parenting* (Dinkmeyer & McKay, 1983), and *The Family Game: A Situational Approach To Effective Parenting* (Hersey & Blanchard, 1978). The *STEP/Teen* sessions focus upon communication, responsibility, family meetings, conflict resolution and limit setting.

Goals of the program include the development of independence and responsibility on the part of the teen. This goal focuses on knowing that the alcoholic or addict is adept at manipulating, triangulating, involving family as enablers or codependents, and keeping the family in a crisis state (Dinkmeyer & McKay, 1983). Alcohol or drug use may be an attempt to exert power over one's parents, or a sign of feelings of inadequacy, and low self-esteem. Therefore, the program focuses upon positive goals, encouragement, cooperation, and concern. Parents are taught that behavior changes take time, and a change in approach is necessary in order to avoid power struggles.

The Family Game approach includes an analysis of parenting styles, from directive to supportive, as the maturity level of child increases. Parents learn to evaluate their approach to parenting. During Family Lab sessions parents, family members, and adolescents are given the opportunity to role-play previous problem situations, and practice alternative responses or behaviors.

Effectiveness of Family and Activity Therapies

How effective are the proposed treatment modalities: family therapy; and leisure education or counseling? Due to a lack of conceptual clarity concerning alcoholism and addiction, treatment programs tend to be comprehensive or all-inclusive, offering a wide variety of treatment modalities and therapeutic activities (Parihar & Kirchhoff, 1985). These authors point out that this array of services makes it difficult to evaluate the effectiveness or contribution of one modality toward recovery. To explore these difficulties, they conducted a pre-experimental study to determine the relationship between treatment variables and outcome behavior. Family therapy sessions were correlated with favorable outcomes, although less significantly than six other variables including length of stay, number of individual sessions, group therapy sessions, activity sessions, number of AA meetings, and film-discussion sessions studied. No statistically significant results were reported.

Activity therapy sessions were correlated positively with positive outcome, in contrast to other *group* treatment varieties (Parihar, & Kirchhoff 1985). The authors attribute this effectiveness to the unique approach of activity therapy. Such unique aspects, according to Parihar and Kirchhoff, include: the use of a variety of activities from social skills exercises to handicrafts, etc.; the individual focus within a group milieu; and client perception of this therapy as *fun*.

Based upon this review of the literature and the clinical approach employed by the adolescent treatment program, the Family Lab, or interdisciplinary family leisure program, was designed and implemented. Assessment procedures, program activities and evaluation/follow-up procedures are described below.

Implementation of an Interdisciplinary Family Leisure Education Program

Family Lab Assessment Procedures

The family therapist completes a social history which includes information regarding family social and leisure interests and participation. The adolescent client completes a structured-interview format leisure assessment. This assessment focuses on leisure needs, history, present interests, strengths and limitations, and on the developmental tasks of adolescence. Adolescent assessment issues should include separation from parents, individual responsibilities and identity, gender identity, values clarification, and peer influence.

O'Morrow and Reynolds (1989) point out that adolescence is a period of transition from the expectations and competencies of childhood to a new set of expectations and competencies. Erikson discusses the adolescent identity crisis and notes that "at no other stage of the life cycle are the promise of finding oneself and the threat of losing oneself so closely allied" (Erikson, 1968, cited in O'Morrow & Reynolds, 1989, p. 255). Chemical abuse may be a dysfunctional adolescent response to these social stresses.

Following individual and family assessment, referral to the appropriate family program is made by the treatment team for each client who has family members available and willing to participate. Family leisure education (the Family Lab) is included within the interdisciplinary treatment plan.

Further assessment of family members' leisure interests was initially attempted using a computer analyzed instrument (Edward's 1980 Constructive Leisure Activity Schedule, as recommended by DiLorenzo et al., 1987). However, limitations on staff time and lack of computer access made this approach impractical. Programs wishing to incorporate this element of assessment should use an interactive computerized leisure interest inventory such as LeisurePREF (Edwards, 1986) to be most time-efficient. In this case, clients enter results directly on the computer. Data entry and analysis is facilitated as the computer categorizes and interprets the scores. If such a program is instituted, determining common leisure interests of family members would aid in treatment planning during hospitalization, and in planing for activities on therapeutic leave assignments and following discharge.

Family Lab Program Interventions

The Family Lab is one of several components of the Adolescent Family Treatment Program. Families participating in this program meet individually with a family therapist four times during the course of

treatment, and attend 6-8 Family Program sessions on successive Sundays. Sunday afternoon activities consist of three sessions of approximately 1½ hours each. They are (a) Parents' Class, educational sessions for parents only focusing on parenting techniques; (b) Family Lab, family interactive/leisure education sessions with topics coordinated weekly with material covered in that day's Parents' Class; and (c) Family Group, group family therapy.

The Family Lab is a series of scheduled, prescribed activities designed to fulfill diagnostic needs of the clinical staff and provide instructive and therapeutic benefits to the family. Family Lab provides parents with opportunities to practice parenting and communication skills learned in Parent's Class. The experiences in Family Lab also provide material to be processed in succeeding Parents' Classes, and in family therapy sessions. Activities are monitored actively by clinical staff, and direct support can be provided to the families who are reaching the limits of their family's ability to deal with the task and stress of the activity. The Family Lab is designed to be a precipitous experience which serves to (a) manifest the symptoms of the parent-child relationship; (b) support the family when necessary; (c) assist the family in identifying and owning their dysfunctional behaviors; (d) assist the family to use new skills; and e) increase their family leisure awareness and range of leisure interests. Focus is on enlarging the family's ability to practice healthy forms of interaction and communication.

Family Lab leisure education group sessions are designed to address the admonitions of the codependent family: DON'T TALK, DON'T FEEL, DON'T TRUST, DON'T ENJOY. Sessions are 1½ hours in length and are facilitated by the recreation therapist, with assistance from other interdisciplinary staff members including family therapists and counselors. Warm-up activities are designed for enjoyment and stimulation of *The Child Within*. Sessions I-VII are outlined below.

I. Don't enjoy: introduction to leisure counseling (values clarification). Goals of the session: to have the family successfully plan an activity and become aware of how communication patterns influence effective problem solving. The family will learn that good experiences or family leisure happenings require planning and choice.

A. *Warm-up activities*: The NameGame is an example of an appropriate warm-up activity. Introduce family members to other families. Relate their name and name of animal (or vegetable) which begins with the same letter: "I'm Ann, and I'm an aardvark", etc. Such a warm-up activity serves to introduce participants to members of other families, to *break the ice*, reduce inhibitions, and introduce families to interactive, participatory activities.

B. *Discuss benefits of leisure, family leisure needs, barriers to constructive use of leisure time, and community resources*. Use brainstorming techniques on a blackboard to elicit responses from participants.

C. *Assess family leisure preferences*. Use LeisurePREF (Edwards 1986) as the proposed computerized assessment if access to interactive computers is available. Have family members develop a family leisure collage--*leisure favorites* by collaboratively constructing a collage which illustrates their family leisure pursuits. Materials provided include poster board, magazines, scissors, glue, marking pens. The activity serves to clarify family leisure values and interests and to allow observation of how well the family organizes itself around a task and divides task responsibilities, verbal and non-verbal communication patterns, and how well the family allows for individual expression. It also provides the opportunity to identify enabling and *using* dynamics, to observe who in the family is active in the planning process, and to complete the project and process with the recreational therapist in small groups.

II. Don't trust: trust exercises. Goals of session: to explore and experience trust within the family in a positive way. To observe for levels and kinds of anxiety and discomfort, and to see how family reacts to this.

A. *Warm-up activity: The Wave*. Ask the group to sit in a circle on chairs. Beginning slowly at first, practice football stadium wave action, proceeding more rapidly around circle as you continue.

B. *Trust Walk*: A family member guides a blindfolded partner on a ten minute walk. Then the roles are reversed. *Willow in the Wind*, allows family members to take turns standing in the middle of a tight circle of other family members. The individual in the center leans into supporting hands and is gently passed around the circle. The purpose of the exercise is to explore issues of trust/distrust. It enables various family members to practice

dependent/independent roles and to process the results of these exercises in group setting.

III. Don't feel: feelings activities. Goal of session: to observe for suppression of feelings or expressiveness that would cover or defend denial and to assist family members with validating each other's feelings and thoughts during the family activities.

A. *Warm-up activity: Zoom.* Participants sit in a circle, and *pass* the word *Zoom* from the person on their left to the one on their right, etc. The activity is timed as it completes a circle for zoom *world record.*

B. *Encouragement Game:* Each family member is to write positive statements on each individual's paper, resulting in a list of positive statements accumulated by each. Discuss and process the results in the group.

C. *Positive Affirmations:* Positive affirmations involve standing behind each individual family member, with hands of their shoulders, and making a positive statement to that individual. Discuss and process feelings revealed in group. The activity allows participants to express feelings openly to other family members. It enables a positive expression of feelings to counteract previously negative interactions.

IV. Don't talk: communication activities. Goal of session: to encourage family members to participate in a variety of communication exercises in order to enhance awareness of verbal and non-verbal communication patterns.

A. *Warm-up activity:* Untangling Human Knot (problem-solving). With one family member out in the hall, families form a circle holding hands, then knot the circle. The absent individual returns and *un-knots* the group.

B. *Back to Back Activities* (conversation, designs, drawings). Participants are paired and seated back to back. They practice communicating or conversing without non-verbal clues, then they face each other and continue conversation. Participants discuss reactions to this exercise. Pairs then return to the back to back position. The first participant is given a pen and paper on which draw on, or 10 toothpicks or popsicle sticks to create a picture or design. The first individual instructs the partner to reproduce the drawing or design, one-way (giving directions only) and two-way (allowing questions and clarification). Communication patterns are practiced and the results of this exercise are processed (see Carter, Van Andel & Robb, 1985, pp. 121-25).

Blindfold Exercises (verbal and non-verbal). Blindfolded groups of 10-14 (two or more families) are asked to sort themselves verbally, by height and non-verbally, by shoe size. Patterns of communication and leadership are then discussed.

The purpose of these activities is to enhance awareness of previous communication styles and patterns and to provide an opportunity to practice newly learned communication methods.

V. Don't talk, don't trust, don't feel: leisure role play (to coordinate with Parent's Class Parenting Skills Session). Goal of session: to provide patients and family members the opportunity to act out family roles and patterns. The exercise will expose examples of dysfunctional responses to the *using* attitudes and behaviors of adolescents to substitute therapists and other program participants. It can reverse family roles in order to help families gain insight into their dysfunctional behaviors. It provides the chance to discuss and clarify leisure and social issues and values for family.

A. *Parenting Styles.* Discuss changes from authoritarian to democratic parenting styles as teen becomes more mature and responsible. Increase awareness of interaction styles, and power and control issues. Stress open communication between parents to avoid triangulation by teens. An introductory session with only parents present reviews these parenting issues.

B. *Expressive Therapy Warm-up.* Practice mirroring or pantomiming activity briefly to reduce inhibitions of group and to begin to introduce interactive drama techniques (Thurman & Piggins, 1982). The activity increases awareness of non-verbal aspects in communications and *role playing.*

C. *Activity: Leisure-oriented Role Plays.* Role plays improve communication and interaction patterns within the family. Sample scenarios include the following:

> Your 15 year old son is planning to attend a concert with friends. You are concerned since many attending the concert may be drinking and using drugs.
>
> Your 16 year old daughter has begun dating and requests permission to date on week nights. You are concerned that her social life will interfere with homework.

VI. Don't talk, don't enjoy: family leisure contract. Goals of session: to allow the family to successfully plan an activity, complete written contract, and learn that positive family leisure experiences may require planning, choice, and negotiation between family members.

Complete a written *Family Leisure Contract* (see Appendix) during Family Lab. The family will carry out the planned activity as part of a therapeutic leave assignment prior to the adolescent's discharge. The experience will be reported and processed during a subsequent individual family therapy and recreation therapy session in order to complete the patient's behavioral contract.

The purpose of the activity is to clarify family leisure values and interests, to see how well the family carries out planned experience. It allows observation of how the family accommodates individual choices and preferences in planning a group activity. It demonstrates changed leisure behaviors required to complete the project and to process the results with the family and recreation therapists. Upon completion, it will help to establish patterns for family leisure experiences following discharge.

VII. Don't enjoy: family leisure participation (values clarification: meeting family needs in leisure). Goals of session: to increase awareness of benefits of family leisure participation. In addition, family members learn to relax and enjoy leisure activities as a group while all are sober. The family learns that they can develop and carry out a family experience with a sense of order, accomplishment, and cooperation.

A. *Activity: family leisure needs checklist.* Each family member completes *Family Leisure Needs Checklist* (see Appendix) by ranking his or her top five needs. The results are discussed and processed within the family group, facilitated by staff members. The purpose of this exercise is to make explicit some benefits of family leisure participation, and some individual and group needs which may be satisfied through constructive recreational activities.

B. *Family Leisure Activity* (group participation). The therapeutic recreation therapist and support staff facilitate leisure activities such as *New games*, beachball or blanket volleyball, quiet or active games as appropriate for participants, or picnic with softball or volleyball requiring the teens to cook and clean-up the meal. The purpose of this activity is **enjoyment.** Also, it allows one to assess how well the family carries out various tasks in completing the family activity. It looks at how well the family deals with inability or lack of cooperation on the part of family members. It further allows observation of parenting interactions and how well families, especially parents, employ new communication skills. It allows the therapist to observe for and identify enabling and *using* dynamics.

Evaluation and Follow-up Procedures

Summative evaluation of this program is provided by patient and family satisfaction surveys completed by all participants at the time of discharge. The Activity Therapy Department head reviewed these surveys monthly. He or she noted the ratings of the family treatment program and noted all written comments referring to the adolescent family program as a whole, or the Family Lab in particular. Results of these evaluations were complied as part of the department's quality assurance program. Because these evaluations were carried out for internal review only, results to date are not available. In the future, the authors recommend that a formal research program and statistical analysis be conducted to determine the efficacy of such an approach.

Ongoing formative evaluation procedures are also carried out by the Activity Therapy Department Head as part of the quality assurance monitoring program. Such evaluations determine if the program is being carried out as planned, and if individual clients are meeting indicated treatment goals successfully. Follow-up procedures are the responsibility of the aftercare coordinator. Aftercare is provided free at the treatment center for a period of two years after discharge, and family members as well as individual clients participate. The aftercare coordinator evaluates participation in leisure, social, and support-group activities.

Conclusion

One or more family members with an addictive disease can disrupt the entire family and negatively affect leisure, recreational, and social participation. A review of the literature indicates the significance of both family therapy and activity therapy in the treatment of addictive disease. Family leisure

Education is emerging as valid intervention modality. Experts in adolescent chemical dependency treatment emphasize the need for family involvement in treatment. According to Smith and Sartor, "the single most important predictor of whether an adolescent will achieve success is the level of family involvement" (1988, p. 4).

Many of the dysfunctional patterns evident in the codependent family relate to leisure, recreation, and social issues, and are available to therapeutic recreation intervention. Following discharge, continued work by families in the areas of communication, trust, feelings, and enjoyment is recommended. It is hoped that co-dependency issues can be addressed more frequently within alcohol and drug treatment milieus, and that family leisure counseling/education be incorporated to a larger extent within such programs. In addition, closer examination of the effectiveness of such programs is recommended.

The Family Lab has been designed specifically to meet the needs of families with an adolescent in treatment for substance abuse. The success of this program lies not only in the activities presented, which have been carefully designed with particular purposes in mind, but in the ability of the interdisciplinary staff to process family interactions in a constructive and therapeutic manner. In this regard, it is to be noted that the therapeutic recreation specialist as facilitator was supported by family therapists, family counselors, nurses, and mental health technicians. The therapeutic skills of all staff contributed to the success of this program. Since these were dysfunctional families, the additional staff allowed for the opportunity to break up the group into smaller groups of families in conducting activities, and to remove families in crisis from the session if the need arose. It is recommended that a therapeutic recreation specialist contemplating the implementation of such a program increase his or her family counseling skills through additional coursework or workshops in this area, and insure interdisciplinary staff support.

Programs such as the Family Lab can contribute toward the goal of moving codependent families closer to the *ideal* family. Such a family, according to Secunda, is "a safe harbor for growth, optimism, and a sense of belonging" (1990, p. 54). Such a family will provide commitment, intimacy, and mutual support (Secunda, 1990). The therapeutic recreation profession must respond with sufficient programmatic concern and research effort to the pressing social problem of adolescent substance abuse and the resulting family dysfunction.

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Endnote

Warm-up and program activities are described only briefly. A complete description of procedures is available from Marjorie J. Malkin, Department of Recreation, Southern Illinois University, Carbondale, IL 62901

Appendix

Family Leisure Contract

A contract often serves to define a plan of action. Use the following contract to explore leisure issues and to plan a family leisure experience for a weekend afternoon. You will be expected to carry out this plan as part of a therapeutic leave assignment during treatment.

1. List some leisure activities the whole family might enjoy (may include favorite pastimes or new activities):

   _____

   _____

2. Indicate here one activity the whole family has decided upon:

   _____

   _____

3. What are some of the good things you might experience as you participate in this activity?_____

   _____

   _____

4. What are some barriers that could prevent the entire family from participating?

   _____

   _____

5. Considering the above barriers, do you think a different activity would be more successful? _____

   _____

6. List the activity you have now agreed upon to try: _____

   _____

   _____

* Based upon a clinically revised version of *A Leisure Contract*, McDowell, 1983.

Family Leisure Needs Checklist

It is important to me to:

_____ Spend quality time with family members.

_____ Become physically fit as a family.

_____ Develop family trust.

_____ Build communication in the family.

_____ Be in attractive surroundings as a family.

_____ Enjoy each other.

_____ compete within and without the family.

_____ Improve family decision making.

_____ Make and carry out family plans.

_____ Be spontaneous together.

_____ Relax and take it easy as a family.

_____ Develop feelings of self-worth within the family.

_____ Be proud of each other for accomplishments.

_____ Learn a variety of new skills in leisure together.

_____ Learn to help family members.

_____ Learn new things about family members.

_____ Be creative as a family.

_____ Develop friendship within a family.

_____ Develop tolerance and patience within the family.

_____ Develop common leisure interests.

_____ Be part of family group or team.

*Based in part upon "Meeting Personal Needs in Leisure", Lady & Whipple, cited in Stumbo & Thompson, 1986.

Perception of Client Needs in Chemical Dependency Treatment Programs

Colleen Deyell Hood, M.S., C.T.R.S

Abstract

Therapeutic recreation specialists, program administrators, and clients in chemical dependency treatment programs were surveyed to determine the degree of agreement or disagreement between staff and clients in their perceptions of treatment needs. Client treatment issues were derived from the chemical dependency and therapeutic recreation literature and were broadly categorized into eight areas: physical problems, emotional/cognitive problems, social/family problems, knowledge of leisure, self-awareness related to leisure, attitudes towards leisure, leisure activity skills, and leisure resources. Results indicate that, in general, there are significant differences between staff and clients in their perceptions of treatment needs. However, there were twelve specific issues that most clients and staff agreed upon as being critical for recovery.

The delivery of leisure services to individuals with disabilities, illnesses, or other limiting conditions through therapeutic recreation services is based on the accurate identification of problem areas or needs. Peterson and Gunn (1984) indicated that this identification of needs is an essential prerequisite to quality program development and client assessment. Bullock, McGuire, and Barch (1984) found that the identification of client needs which can be met through leisure is one of the top five research priorities identified by therapeutic recreation professionals.

There is evidence to indicate that, in general, staff and clients in psychiatric and chemical dependency treatment programs do not agree on the identification of treatment needs (Dimsdale, Klerman, & Shershaw, 1979; Jordan, Roszell, Calsyn, & Chaney, 1985; Mayer & Rosenblatt, 1974). The degree to which clients and therapists concur about treatment needs directly affects the outcomes of treatment (Hurst, Weigel, Thatcher, & Nyman, 1969; Starfield et al., 1981).

Jordan et al. (1985) found that client and staff perceptions of treatment needs in a chemical dependency setting also were markedly different. They indicated that patients participated more actively and displayed more commitment to treatment groups that they rated as important. Jordan concluded that including patients in treatment planning increases the likelihood of active participation; not including patients reduces their commitment to the treatment program. Rollnick (1982) further indicated that patients who disagreed with staff in relation to treatment issues often had poor relationships with staff and, as a result, experienced less success in treatment.

There are two general approaches to treatment within the area of chemical dependency. The first approach (the unitary model) is based on the concept that addiction is the primary problem and that any other functional problems are a result of the addiction (McLellan, Luborsky, Woody, O'Brien, & Kron, 1981). Abstinence is the main criterion for evaluation of treatment effectiveness (Hart, 1977). The second approach to the treatment of chemical dependency is labelled the multidimensional approach (Hart, 1977). This approach emphasizes the psycho-social problems (such as physical health, social activities, psychological state, and occupational performance) and the patterns of these problems exhibited by chemically dependent individuals. These psycho-social areas are the primary focuses of treatment. It is felt that the remediation of the addiction and return to a high level of functioning is dependent on a variety of factors, not merely abstinence, though abstinence remains an important aspect of recovery. The multidimensional approach is used frequently as a framework for the delivery of

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chemical dependency treatment services. It provides the theoretical base for this study.

This exploratory research identifies those addiction related problems which therapeutic recreation specialists (TRSs), program administrators and clients agree are problems in leisure during recovery. It specifically addresses the following research questions: (a) are there differences between client, TRS, and program administrator perceptions of treatment needs, and (b) which treatment needs are identified by staff and clients as being important in recovery? For study purposes the terms *treatment needs* and *addiction related problems*, relating to client issues to be addressed through treatment are considered synonymous.

Method

Subjects and Data Collection

Data were collected by TRSs working in chemical dependency treatment programs. Initially, 43 agencies identified through the American Therapeutic Recreation Association, the National Therapeutic Recreation Society, and the University of Illinois internship list were contacted to request assistance with this project. Each of these agencies was a separate chemical dependency facility, unit or program within a larger facility where clients averaged a 30 day length of stay. Of the 43 agencies contacted, nine participated in the data collection process (a response rate of 21%). However, not all nine were able to collect the requested ten client questionnaires, primarily due to low census within their programs. The agencies that did not participate in the data collection procedures cited several reasons for non-participation: lack of adequate numbers of clients, lack of clients who fit the stated criteria, lack of support from agency administrators, and lack of time and/or staff to conduct the data collection procedures. The total sample reported herein consisted of nine program administrators, 11 TRSs, 39 early-treatment clients, and 40 later-treatment clients.

One TRS from each agency administered questionnaires to ten clients and one program administrator, and completed a TRS questionnaire. In one instance, three TRS's working in the chemical dependency unit each completed a TRS questionnaire. If a client were unable to complete the questionnaire independently, the TRS was directed to assist the client by reading the questions out loud, etc. To explore the impact of treatment involvement on perception of treatment needs, two client groups were included. The first group consisted of five clients who completed the questionnaire during their first week in treatment (early-treatment clients) and the second group consisted of five different clients in their last week of treatment (later-treatment clients). The selection of clients was based on pre-determined criteria including being over the age of 18, having no prior chemical dependency treatment, voluntary admission, and willingness to participate. The selection of the early-treatment clients did not rely on random sampling methods. The first five clients who were admitted after the beginning of the data collection, and who met the stated criteria for involvement, were asked to participate by completing a client questionnaire. The selection of the later-treatment client utilized random sampling methods. The TRS identified each client who was in the program as a first admission and randomly selected five names from this group. Clients who were included in the early-treatment group were not included in the later-treatment group. Each of the later-treatment clients completed a client questionnaire prior to discharge during their last week of admission, usually the fourth week of treatment.

Experimental Design

This study was accomplished by comparative survey design. The responses of different groups of subjects were compared to determine areas of consensus and areas of difference. The independent variable in this study was the classification of the individuals completing the questionnaire. This variable is divided into four groups: TRSs, program administrators, early-treatment clients, and later-treatment clients. The dependent variables were the 43 problem statements clustered in the eight subscales identified within the literature: physical, emotional/cognitive, social, leisure knowledge, self-awareness related to leisure, leisure attitudes, leisure activity skills, and leisure resources.

Instrument

The study instrument was a self-reported questionnaire developed through extensive review of the literature. Items representing treatment needs

were generated from a literature review and through interaction with therapeutic recreation professionals working in the field. Each psycho-social problem category related to chemical dependency identified in the literature was reviewed to determine if the problem was appropriate for therapeutic recreation intervention.

Three categories, physical problems, emotional/cognitive problems and social/family problems, were identified as appropriate and were translated into behavioral problem statements. Areas directly related to leisure involvement and functioning were derived both from the literature and from the *Leisure Ability Model of Therapeutic Recreation* (Peterson & Gunn, 1984), selected for its wide use in practice and its endorsement by the National Therapeutic Recreation Society. The categories derived from the model and the literature were knowledge of leisure, self-awareness, attitudes towards leisure, leisure activity skills, and leisure resources. These areas also were translated into behavioral problem statements.

The subscales and items on the questionnaire were reviewed by a panel of experts to determine the validity of the items and subscales. This panel consisted of two practitioners and one faculty member with expertise in the area of therapeutic recreation and chemical dependency treatment. Based on the literature and the review by the panel of experts, the eight content areas or subscales were translated into 43 behavioral problem statements. The eight subscales and their respective items are depicted in Table 1.

The behavioral problem statements were reviewed by a panel of experts to evaluate the validity of the items. The panel of experts included TRSs with expertise in chemical dependency and therapeutic recreation educators. Each questionnaire also contained demographic and informational questions specific to the individual (client, TRS or program administrator) completing the questionnaire.

Table 1
Questionnaire Subscales and Items

Subscale	Specific Items
Physical Problems:	Lack of physical fitness.
	Not being very healthy.
Emotional/Cognitive Problems:	Difficulty solving problems.
	Difficulty making decisions.
	Questioning own self worth.
	Difficulty appropriately expressing feelings.
	Experiencing feelings of boredom.
	Difficulty coping with stress.
	Difficulty in concentration.
	Feeling depressed.
	Questioning own abilities.
Social Problems:	Lack of friends who don't drink or use drugs.
	Not feeling comfortable in social situations.
	Not knowing how to talk with others.
	Difficulty being assertive.
	Not having many friends.
	Difficulty cooperating with others.
	Feeling uncomfortable talking with others.
	Lack of people to do things with in leisure.

Table 1 Continued
Questionnaire Subscales and Items

Subscale	Specific Items
Knowledge of Leisure:	Not understanding what leisure is. Lack of awareness of the variety of possible places for leisure. Being unaware of the benefits of leisure.
Self-Awareness:	Difficulty having fun. Not taking responsibility for own actions in leisure. Not feeling in control. Difficulty being playful. Lack of interest in community leisure opportunities. Preferring to do activities alone. Wanting to know outcomes before becoming involved. Preferring passive activities. Difficulty feeling spontaneous. Desire for order and structure in leisure experiences. Not taking responsibility for own actions. Not understanding where leisure fits in one's life.
Leisure Attitudes:	Feeling like they should be doing something else when they are involved in leisure. Seeing work as more important than leisure. Viewing leisure as not important.
Leisure Activity:	Not having a variety of leisure skills. Not having a variety of leisure interests.
Leisure Resources:	Lack of transportation for leisure involvement. Lack of money for leisure involvement. Lack of knowledge of leisure resources available in the community.

The subjects responded to the following directions: "Please indicate the extent to which you think each of the following is a problem for you (your clients) in your (their) leisure during recovery." Subjects were not asked to directly evaluate whether the problems could be addressed through therapeutic recreation intervention. The assumption was that the problems which arise during leisure would be most appropriately addressed through therapeutic recreation intervention. Staff and clients rated all 43 items on a four-point Likert scale with 1=often a problem, 2=sometimes a problem, 3=rarely a problem, and 4=never a problem. The instructions were specifically designed to represent the current process of program development and implementation, in that, staff generally base program development decisions

on their understanding of general population characteristics and needs, rather than upon each individual client's specific problems.

Data Analysis

The independent variable in this study is the classification of individuals completing the questionnaire. This variable is divided into the four groups previously defined in experimental design section. The dependent variables are the 43 problem statements clustered in the eight subscales identified within the literature as previously described. Cronbach's alpha was used to assess the reliability of each of the scales (Cronbach, 1984). This measure indicates the degree of internal consistency of items that make up a scale and considers the relationship between each variable and every other variable in the subscale in all possible combinations. This measure is appropriate for use when the items in the subscales have no correct or incorrect answers (Cronbach, 1984). Perfect internal consistency is indicated by a value of 1.00. A value of 0.5 or higher is considered acceptable in the social sciences (Thorndike & Hagen, 1977).

Multivariate analysis of variance (MANOVA) which assesses the interdependence among the dependent variables while minimizing Type I error, was used to examine the differences between the four groups of the independent variable on the eight dependent variable subscales. This analysis was conducted to determine if there were differences between the TRS, program administrator, early-treatment client and later-treatment client perceptions of treatment needs appropriate for therapeutic recreation intervention.

The research question regarding the importance of treatment needs by the four groups of individuals was addressed by calculating means and standard deviations for each subscale, and for each item within the subscale, to determine the degree of importance in recovery. Frequencies of responses on each item also were calculated to determine those items most often considered to be a problem by staff and clients.

Results

Each client completed questions related to demographic information. The mean age of the clients was 35.8 years, the majority of clients were male (82.3%). Almost one-third (30.4%) of the clients had completed high school, 29.1% had some college education. A large percentage of clients were married (40.2%) and were employed full time (73.4%). The primary diagnosis was alcohol abuse for 38% of the clients, drug abuse (other than alcohol) for 29.1%, and a combination of the two for 21.5% of the clients. T tests were used to compare early-treatment clients and later-treatment clients. These tests showed that there were no statistically significant differences ($p < .05$) between the two groups of clients in all but one demographic variable. This variable, the degree of client insight, was based on a rating, attempting to address the issues of denial, by each client's therapist. The results of the t test indicated that there were significant differences between the two groups of clients ($t(75) = 2.09$, $p < .05$) on this measure. The later-treatment clients were rated as having significantly more insight than the early-treatment clients. Table 2 presents more specific information related to client demographics.

Information related to the TRSs indicated that the majority of the TRSs were educated at the Baccalaureate level (63.4%), had more than five courses related to therapeutic recreation (81.1%), and at least two courses related to chemical dependency (60%). Over 70% of the TRSs had been employed in chemical dependency treatment for at least two years, two TRSs were Certified Alcoholism Counselors or possessed some equivalent certification. One TRS was in recovery. All of the TRSs completing the questionnaire indicated that they utilize the *Leisure Ability Model of Therapeutic Recreation*. For more detailed information, see Table 3.

The program administrators were primarily educated in the area of chemical dependency (50%). Other areas of preparation included nursing (12.5%), social work (12.5%), and counselling (25%). The majority of administrators (62.5%) had been employed in their current position for at least one year. Over 50% of the administrators had been employed in chemical dependency treatment for at least eight years. Most of the administrators (87.5%) indicated that they understood therapeutic recreation content and services quite or very well.

Results of the Cronbach's Alpha indicated that seven of the eight subscales had acceptable Alpha coefficients (.6980 to .9144), while including all items on the scale. The last scale, Leisure Resources, had an initial alpha coefficient of .5891

Table 2
Client Demographic Information

Variable	Early-Tx (n=39)		Later-Tx (n=40)		Combined (n=79)	
	f	%	f	%	f	%
Age						
18-29	11	28.2	13	32.5	24	30.3
30-39	19	48.7	13	32.5	32	40.5
40-49	6	15.4	9	22.5	15	19.0
50-59	2	5.1	3	7.5	5	6.3
60-69	1	2.6	2	5.0	3	3.8
M	34.9		36.55		35.8	
Sex						
Men	33	84.6	32	80.0	65	82.3
Women	6	15.4	8	20.0	14	17.7
Educational Level						
Less than high school	9	23.1	11	27.5	20	25.3
High school graduate	14	35.9	10	25.0	24	30.4
1-3 yrs of college	10	25.6	13	32.5	23	29.1
2 yr professional degree	3	7.7	4	2.5	4	5.1
College or university degree or more	3	7.7	4	10.0	7	8.8
Marital Status						
Never married	10	25.6	13	32.5	23	29.1
Married	17	43.6	15	37.5	32	40.2
Divorced	6	15.4	7	17.5	13	16.5
Separated	6	15.4	3	7.5	9	11.4
Widowed	0	0	1	2.5	1	1.3
Employment Status						
Employed full time	29	74.4	29	72.5	58	73.4
Employed part time	1	2.6	1	2.5	2	2.5
Not employed	6	15.4	6	15.0	12	15.2
Never employed	1	2.6	1	2.5	2	2.5
Retired	1	2.6	2	5.0	3	3.8

Table 2 Continued
Client Demographic Information

Variable	Early-Tx (n=39)		Later-Tx (n=40)		Combined (n=79)	
	f	%	f	%	f	%
Days in Treatment						
1- 5	18	46.2	0	0	18	22.8
6-10	15	38.5	0	0	15	19.0
11-15	5	12.8	5	12.5	10	12.7
16-20	0	0	15	37.5	15	19.0
21-25	0	0	8	20.0	8	10.1
26-30	1	2.6	10	25.0	11	13.9
31-35	0	0	1	2.5	1	1.3
36-40	0	0	0	0	0	0
41-45	0	0	1	2.5	1	1.3
M	7.03		21.85		14.54	
Diagnosis						
Alcohol Abuse	10	25.6	20	50.0	30	38.0
Drug Abuse	15	38.5	8	20.0	23	29.1
Mixed (Drug and Alcohol)	9	23.1	8	20.0	17	21.5
Missing	5	12.8	4	10.0	9	11.4
Degree of Client Insight						
Almost no insight	4	10.3	1	2.5	5	6.3
Very little insight	10	25.6	7	17.5	17	21.5
Some insight	20	51.3	17	42.5	37	46.8
A great deal of insight	5	12.8	13	32.5	18	22.8

Note: f=frequency %=percentage

Table 3
Therapeutic Recreation Specialist Demographic Characteristics (n=11)

Variable	Frequency	Percentage
Length of Employment in Chemical Dependency		
0-6 months	2	18.2
2-5 years	5	45.4
More than 5 years	3	27.3
Certified Alcoholism Counselor?		
No	8	72.7
Yes	2	18.2
In Recovery?		
Yes	1	9.1
No	9	81.8
Philosophy of Therapeutic Recreation		
Therapy to improve functional behavior.	0	0
Services to promote independent functioning.	0	0
Development of an appropriate leisure lifestyle.	11	100
Provision of opportunities for recreation participation	0	0
Educational Background		
Baccalaureate degree in TR	7	63.4
Master's degree in TR	3	27.3
Number of therapeutic recreation courses		
Five	1	9.0
More than five	9	81.1
Number of Specific CD Courses		
Part of a course	1	9.0
One	2	18.2
Two	4	36.4
More than three	2	18.2

but the alpha coefficient rose to .7194 when one of the items, lack of knowledge of leisure opportunities available in the community, was deleted. Therefore, this item was deleted for the remaining analysis. An analysis of the specific research questions revealed the following results.

Are there differences between early-treatment client and later-treatment client perceptions of treatment needs? The MANOVA results indicated that there were no statistically significant differences between early-treatment clients and later-treatment clients ($F(1,95) = 1.4$, $p > .05$) on their subscale scores. Additionally, each subscale was examined in isolation for each group and there were no differences. As stated previously, analysis of the demographic information using t tests and descriptive statistics indicated that these two groups of clients were not significantly different from each other, except in the number of days in treatment and degree of insight. The difference in degree of insight did not appear to affect the perception of treatment needs, therefore these two groups were combined for further analysis.

Are there differences between TRS and program administrator perceptions of treatment needs? The MANOVA results also indicated that there were no statistically significant differences between TRSs and program administrators ($F(1,95) = .41$, $p > .05$). Additionally, when each subscale was examined in isolation, using ANOVA, for each of these groups, no differences were found.

Are there differences between staff, combining TRSs and program administrators, and client, combining early-treatment and later-treatment clients, perceptions of treatment needs? Statistically significant differences between all staff and all clients ($F(1,95) = 13.65$, $p < .000$) were found to exist. These differences also appeared when each subscale was analyzed separately.

Which treatment needs are identified by staff and clients as being important in recovery? Each item on the subscale was rated as to the degree the item was a concern in recovery. A low score (1) indicated that the item was perceived as often being a problem while a high score (5) indicated that the item was perceived rarely or never as a problem. Mean scores and standard deviations for each item for each of the four groups were calculated to determine the relative rankings of the items. This analysis of the items on each subscale indicated that over 80% of staff rated most of the problems as being sometimes or often a problem. The TRSs identified this as being true in 91% of the cases, program administrators, 95%. There was less agreement on the ratings of specific items by clients.

Within each group of clients (early-treatment and later-treatment), over 50% perceived 16 of the 43 items as sometimes or often a problem. The ratings of the remaining items were fairly evenly split as to whether the item was perceived as a problem. Of the 16 items each group of clients perceived as problems, 12 items were common to both groups. As indicated in Table 4, these 12 items also were identified as sometimes or often a problem by staff.

Discussion

The findings of this study indicate that there were no differences between early-treatment clients and later-treatment clients in their perceptions of their own treatment needs. No differences were found between TRSs' and program administrators' perceptions of their clients' treatment needs. However, significant differences did exist between staff's and clients' perception of treatment needs. Additionally, staff generally rated most of the items as being often or sometimes a problem. Clients showed much less agreement on the rating of problems. It is interesting to note that there were 12 items which both clients and staff agreed were treatment needs that should be addressed for recovery.

The ability to generalize results of this study are limited due to the small sample size and design limitations. However, they do contribute to the body of evidence indicating that discrepancies between clients and staff in the identification of treatment needs exist. This discrepancy may be explained in one of several ways.

First, clients may have an accurate perception of their treatment needs while staff do not. If this were true, the assessments and programs designed by staff would not address the treatment needs identified by clients. Second, staff may have an accurate perception of client treatment needs while clients do not. This second notion may have been accepted in the past, but current literature indicates that clients in psychiatric and chemical dependency treatment do have the ability to accurately identify their own

Table 4
The Twelve Items Identified as Being Sometimes or Often a Problem by Clients and Staff

Item	Percentage Rating Item as a Problem			
	Early-Tx	Later-Tx	TRS	Program Ad.
1. Experiencing feelings of boredom.	75.7	63.2	90.9	100.0
2. Feeling depressed.	65.8	70.3	100.0	100.0
3. Difficulty appropriately expressing feelings.	65.8	66.6	100.0	100.0
4. Lack of friends who don't drink or use drugs.	71.8	55.0	100.0	100.0
5. Difficulty coping with stress.	63.8	63.2	100.0	100.0
6. Difficulty communicating with family.	64.8	61.5	81.8	100.0
7. Lack of interest in community leisure opportunities.	68.4	55.2	100.0	100.0
8. Questioning their own self worth.	50.0	65.8	90.9	100.0
9. Not feeling comfortable in social situations.	54.0	59.0	100.0	100.0
10. Not feeling in control.	55.2	55.0	100.0	87.5
11. Lack of physical fitness.	53.9	55.0	90.9	100.0
12. Feeling like they should be doing something else when involved in leisure.	51.3	51.3	81.8	87.5

treatment needs (Fitzgibbons, Cutler, & Cohen, 1971; Leonard, Dunn, & Jacob, 1983).

A third possible explanation for the differences between staff and clients is that neither has an accurate perception of treatment needs. Finally, both clients and staff may have accurate perceptions of treatment needs.

Even though the results indicate that there are differences, both groups may have accurate perceptions of treatment needs. Staff may be referring to population treatment needs (clustered needs based on general population characteristics), while clients are focusing on their own personal, individually-focused treatment needs. This possibility likely arises as a result of instrumentation. Clients were directed to identify specific problems they experience and staff were directed to identify problems experienced by all their clients. This approach to the identification of treatment needs in all probability is reflective of the process of assessment and program development currently used in the field. Ideally, each TRS should have completed a questionnaire for each client included in the study. This was not possible due to the time constraints of the TRSs.

Realistically, most therapeutic recreation assessments and programs are based on perceptions of general client characteristics. If this explanation is correct, TRSs may choose to incorporate opportunities to address specific individualized client issues into both the assessment process and program development

It appears there is a discrepancy between staff and client perceptions of treatment needs. This discrepancy has implications for the delivery of services in chemical dependency treatment as well as for the efficacy of the treatment. If the programs being delivered do not address the needs that the clients feel are important, then the efficacy of the programs may be limited. Perhaps one reason

Alcoholics Anonymous (A.A.) is relatively successful in assisting individuals to maintain sobriety is that the clients determine which recovery areas to address and facilitate the process themselves. Treatment programs, although often based upon A.A. philosophy, do not historically have the same success rate as A.A. A possible explanation, perhaps, is the level of staff determination of treatment needs addressed in treatment programs.

The fact that staff and clients are not in total agreement as to which problems occur most often has an impact on all aspects of the delivery of services. The assessments developed and conducted by staff will likely reflect their perceptions of the problems clients in chemical dependency treatment face as a group rather than the issues identified by the individual client. The programs developed to address client needs, therefore, likely reflect the therapist's perception of the needs of the population rather than the self-perceived needs of the clients. The evaluation of client progress also is likely based on the staff perception of needs and progress.

The literature indicates that clients often respond negatively to discrepancies in perceptions of treatment needs (Friedman & Glickman, 1986; Hurst et al., 1969; Jordan et al., 1985; Rollnick, 1982; Selzer, 1977; Starfield et al., 1981). Clients who are involved in a treatment program that does not address the needs they think are important may be less cooperative with the treatment process. Clients may be less invested in a program that does not address the needs they think are important. It also may be possible that a discrepancy in perception of treatment needs plays a role in premature discharges as patients would likely perceive the programs ineffective in addressing their needs.

A significant implication is that staff solicit and encourage client involvement in treatment planning. While it is impossible to develop programs to address each individual need, time should be available to work with clients on an individual basis if necessary. Flexibility also should be incorporated into programs to allow clients the latitude to direct content where it is most personally relevant. This discussion of the role of clients in determining treatment plans and interventions does not negate the significant impact of client denial on the chemical dependency treatment process. However, clients may be more invested in and committed to a treatment plan which incorporates their own perceived needs as well as needs identified by staff.

The finding that there was agreement on some of the problem statements indicates that there are problems that stand out to both clients and staff as being important. Although this study does not directly address the validity of clients' or therapists' identification of treatment needs, the literature indicates that clients have the ability to identify their own treatment issues. Therefore, problems identified as important by both staff and clients appear to be critical issues in recovery and may provide direction for therapeutic recreation services. This issue is an important consideration when deciding the degree to which clients will be involved in their own treatment planning.

This study also provides directions for future research. First, research is needed regarding the development of refined and validated measures of treatment needs, addressing issues such as reliability of scales, and content and construct validity. Thorough examination of the significance of differences in ratings between staff and clients would prove valuable information for program development. Likewise, so would assessments to determine which treatment needs are most and least agreed upon. Examination of the impact of disagreement between staff and clients on treatment outcomes also would be useful. Further examination of factors such as; educational level, philosophical position, sex, alcoholism and employment history, which may affect both staff and client perceptions of treatment needs, may provide much needed information about staff identification of treatment needs.

Development and testing of model programs based on the identification of treatment needs is recommended. These programs could then be utilized in studies that address the impact and efficacy of therapeutic recreation services. Development and validation of assessment instruments for use in clinical settings, based on the identification of treatment needs, also would be a significant contribution to the therapeutic recreation profession. Finally, a study that addresses the role of therapeutic recreation in recovery may provide justification and validation for the inclusion of therapeutic recreation in chemical dependency.

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Caregivers, the Hidden Victims: Easing Caregiver's Burden through Recreation and Leisure Services

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Abstract

Caregivers, especially those who voluntarily care for parents, adult children and relatives, experience great stress, strain and *burden* in their roles. The literature suggests that caregivers identify loss of leisure and recreation as a contributing factor to their burden. However, no support or treatment programs for caregivers were identified that included either education or training for leisure and recreation in their services. The purpose of this paper is to describe the caregiver population, identify their areas of need, illustrate how leisure and recreation might benefit them, and discuss the currently available leisure services and the development of new services for caregivers.

As baby boomers grow older and the average age of society increases, much attention is being directed to the needs of older adults. In therapeutic recreation and other related fields, the literature about disabled older adults, people with Alzheimer's disease, and developmentally disabled adults is emerging (e.g. Rancourt, 1990). Knowledge about the therapeutic recreation needs of these newest target groups, and how recreation and leisure services can help them, is essential when considering their overall well-being.

Although much of the therapeutic recreation literature focuses on older adults as care recipients, little attention is given to those who provide for their care. These persons, called caregivers, are those who stay at home to aid a disabled or ill relative or friend. Caregivers may be family members, spouses, or friends and neighbors who actually alter their lives to care for someone else (Stone, Cafferata, & Sangl, 1987). A selective review of the literature described these caregivers as severely stressed and strained by the burden of caring for a disabled family member or friend with little hope of relief (Pilisuk & Parks, 1988; Sheehan & Nuttall, 1988; Stone, Cafferata, & Sangl, 1987; Zarit, 1989). Recreation and leisure pursuits are minimal, if not non-existent. The purpose of this paper is to describe the caregiver population, identify their areas of need, illustrate how leisure and recreation might benefit them, and discuss the existence and development of leisure services for caregivers.

Caregivers Profile

When considering the range and number of disabling illnesses in society, each of us can expect to be a caregiver at some point in our lives (Pilisuk & Parks, 1988). Caregivers can be defined as persons who care for other individuals in either formal or informal capacities. Formal caregiving occurs in nursing facilities and convalescent homes or through in-home health care services. Professionals are hired to care for the disabled and ill older adult. Informal caregiving occurs within the families of the care recipient and takes place primarily in the home. These informal support groups include not only families, who are usually spouses and children of the care recipient, but also friends and neighbors. Cantor (1983) suggested that it is the informal support systems that provide the majority of assistance to care recipients.

Informal caregiving is performed by all types of people; however, caregivers share particular

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characteristics. Stone et al. (1987) described the profile of caregivers as 36% spouses, 37% children, and 27% others, relatives and neighbors. According to U.S. Select Committee on Aging (1988), the majority of informal caregivers to disabled and ill older adults were women (72%), 29% of whom were adult daughters and 23%, wives. Husbands comprised only 13% of this population. The average age of caregivers was 57.3 years; however, 25% were 65 to 74 years (U.S. Select Committee on Aging, 1988). Three-fourths of caregivers lived with the recipients and gave on the average of six hours of care per day (Pilisuk & Parks, 1988).

Caregivers who are spouses and grown children of the care recipient have high likelihood of stress. Of particular note are the vast majority of adult daughter caregivers were married with children of their own, and found to be a "generation in the middle with the potential for considerable stress from situational as well as personal factors" (Cantor, 1983, p. 599). Cantor also found that, in husband/wife caregiving situations, where the couple lived alone at home without children there was "increased the potential for isolation and psychological stress" (1983, p. 599).

In a study of responsibilities of the caregivers, Stone, et al. (1987) noted that while 80% of all caregivers provided unpaid assistance often seven days a week, thirty- one percent of the caregivers were otherwise employed, 29% had to alter schedules to care for the recipient, 20% were forced to cutback on work hours, and 9% left the work force because of time constraints. In a similar study, Brody (1985) found that almost half of the respondents had either quit their jobs or reduced the number of work hours because of caregiving responsibilities.

Characteristics of Burden

A consistent characteristic of caregivers is that these individuals take on additional responsibilities for the care and maintenance of someone who is disabled or frail. These responsibilities often are perceived as a burden for the caregiver. That is not to say that they do not willingly assume these responsibilities; however, adding these tasks requires personally demanding efforts.

Hypotheses of how burden is defined and perceived and the subsequent effects of burden abound in the literature. Although closely related to stress, burden is related primarily to the management of tasks. While burden deals with management, according to Pilisuk and Parks (1988), stress is the appraisal of strain on the caregiver. Pilisuk and Parks (1988) also suggested that to understand burden of care, one must examine both objective burden (physical tasks and financial burden) and subjective tasks to "assess the meaning of events to the individuals experiencing them" (p. 436). Sheehan and Nuttal (1988) proposed that the concept of *role overload* or competing demands on time and resources can create the *burden*, which in turn can cause stress in the caregiver. As a result, the caregiver may experience depression, anxiety, and health problems.

Caregiving does not always involve a spouse or child taking care of an older adult. Elderly parents as caregivers for adult dependent children experience major stress as well (Jennings, 1987). Jennings (1987) suggested that *perpetual parenthood* may contribute to the recognition of caregiver's own aging and the lifelong dependency of the child. Concern about what will happen to the dependent child after the parents' death adds to this burden.

Barusch (1988), in a needs assessment study, sought to design, develop, and evaluate interventions to reduce the stress of caregivers. Common types of caregiver stress were identified as follows: (a) missing the way the spouse was; (b) worrying over what would happen if the caregiver became ill; (c) feeling depressed; (d) feeling lonely; (e) feeling angry; (f) finding it difficult to physically perform care related tasks; (g) and arguments with spouse (Barusch, 1988). Primary problems regarding the caregivers interactions with others were the failure of others to understand what life is like for the caregiver. Personal health problems also were of primary concern. Several other factors can be considered in the perception of burden and stress. Social isolation, lack of respite care, financial or economic need, and infrequent and/or inadequate counseling have been identified as contributors to stress (e.g. Barusch, 1988; Jennings, 1987; Sheehan & Nuttall, 1988; Stoller, 1983).

Caregiver Coping Strategies

Caregivers attempt to cope with the burden of caregiving in several ways. For example, Pratt, Schmall, Wright & Cleland (1985) examined five coping strategies which reduced caregiver burden:

(a) having confidence in problem solving abilities; (b) reframing; (c) passivity or *avoidance response*; (d) using spiritual support; and (e) using extended family.

Barusch (1988) examined problem situations which caused strain in the caregiver's ability to function and the coping mechanism they derived. This study identified that the majority of caregivers either sought help from family and professionals or failed to cope (Barusch, 1988). When viewing the association between coping strategy and coping effectiveness, Barusch (1988) found that caregivers did not always agree on effectiveness of particular strategies. Interestingly, in some cases the strategies that the caregivers perceived to be most effective were in fact unsuccessful. This result suggests that developing coping strategies involves more than just effectiveness.

Sheehan and Nuttall (1988) critiqued four different coping strategies, or caregiver intervention strategies: (a) caregiver education and training, (b) self-help groups, (c) comprehensive service programs, and (d) family therapy. While each was determined to have its good points, a lack of attention to emotional and affective issues in caregiving stood out. Overall support groups designed for, and comprised of, caregivers have proved to be most effective in increasing the caregiver's coping abilities (Winogond, Fisk, Kirsling, & Keyes, 1987; Zarit, Reever, & Bach-Peterson, 1980).

Unmet Leisure Needs

The literature has clearly identified how the stress, strain, and negative responses of caregiving can greatly alter the caregiver's lifestyle, including recreation and leisure and social interaction (Cantor, 1983; Chenoweth & Spencer, 1986; Hooeyman & Lustbader, 1986; Sheehan & Nuttall, 1988; Snyder & Keefe, 1985). The U.S. Select Committee on Aging (1988) specifically noted that "caregivers tend to double up on their responsibilities and to cut back on their leisure time to fulfill all of their caregiver tasks" (p. 27).

In a related study predicting caregiver strain and negative emotion, Sheehan and Nuttall (1988) examined the influence of a variety of factors, including distress and caregiving satisfaction. They defined personal strain as "the extent of physical, social, and financial disruption experienced in the life of the caregiver as a result of caregiving responsibilities" (1988, p. 94). Each subject in the study responded to the degree to which caregiving responsibilities affected job, financial, social, and recreational activities and relationships with others. Results indicated that several subjective factors such as attitude toward caregiving, satisfaction associated with caregiving, distress, and personal conflict with the care recipient played important and complex roles in explaining the negative consequences of caregiving, which in turn potentially affect recreation and leisure satisfaction and pursuits (Sheehan & Nuttall, 1988).

Several studies noted how caregivers adjusted their lives to accommodate their responsibilities. They gave up things that were considered to be marginal to the balance of the caregiver her/himself or the family, such as regular exercise, hobbies, free time for oneself, socialization with friends, vacations, and leisure time pursuits and activities (Barusch, 1988; Cantor, 1983; Snyder & Keefe, 1985). Adjustments were personally restrictive in all cases. Such a philosophy certainly has negative implications for recreation and leisure wellness of the individual.

Similarly, Chenoweth and Spencer (1986) examined factors including major problems facing caregivers of individuals with Alzheimer's disease. Twenty percent felt that the greatest problems involved the inability to get away from home and the isolation from friends and activities. Sixty percent said the relative's illness affected their relationships with others, their leisure activities and social contacts (Chenoweth & Spencer, 1986).

Freedom and free time are rare commodities for caregivers. Montgomery, Gonyea and Hooyman (1985) identified lack of freedom as responsible for the sense of burden reported by caregivers. In a study to assess the amount of burden experienced by caregivers of individuals with dementia, Zarit et al., (1980) found that caregivers identified lack of time for themselves and sleep disturbances as the greatest problems related to caregiving. Shuman and Johnson (1983) also found that caregivers reported a need to spend a portion of their free time alone.

Similarly, Brody and Schoonover (1986) conducted a study that noted how adult daughter caregivers have unique constraints in meeting familial, employment, and caregiver responsibilities which warrant the sacrifice of free time (Brody & Schoonover, 1986; Stoller, 1983). Women

caregivers who are also in the work force, full-time, often experience few changes in household responsibilities. Thus, adult daughter caregivers, in particular, confront very difficult problems in leisure time allocation when their *work* week increases. According to Henderson, Bialeschki, Shaw, & Freysinger (1989), women in general experience traditional gender role related constraints to their leisure activities. The additional role of caregivers may further restrict a woman already suffering from role overload. She most likely will experience or perceive that she has less leisure time.

Caregiving can lead to social isolation, a problem for many caregivers. Studies by Jennings (1987) noted that caregivers often abandon normal social activities. This abandonment is especially true when the caregivers are elderly parents of the care receiver. The effect is cumulative and cyclical: decreased interpersonal interactions lead to isolation, which in turn leads to even less interaction and more isolation (Jennings, 1987). Stephens and Christianson (1986) studied caregiver strain and found over 63% of the respondents found limitations in social life to be a *severe* problem.

Much of the literature identified lack of leisure as contributing to caregiver burden. Similarly, several studies demonstrated how leisure can be brought into one's life to help cope with caregiver burden. According to Barusch (1988), the majority of caregivers (52%) reported little time or energy for activities outside of caregiving. When asked how they coped, they responded that they *just managed*. This approach proved not very effective. Others reported cultivating a support group of friends who shared leisure activities. This group scored above average on mean effectiveness. Solitary action in which persons involved themselves in leisure activities such as letter writing, listening to songs, or going for walks, scored the most effective mean response (4 out of 5). Barusch (1988) suggested that the attraction to these leisure activities might be the flexibility they allow.

Barusch (1988) noted that "caregivers generally reported most success when they changed the situation either on their own or with help" (p. 684). The majority of those who reported loneliness coped by taking direct action that often involved recreation or leisure activities. Examples included activities such as playing cards, reading, talking with friends, and getting out of the house socially. Similarly, many respondents reported that depression was reduced by activities which included going out and playing cards, or simply going for a walk (Barusch, 1988). Additionally, caregivers reported that physical activities and exercise helped them deal with feelings of resentment, guilt, and strain (Barusch, 1988; Chenoweth & Spencer, 1986).

Lack of Leisure Services

Pratt, Schmall, and Wright (1987) conducted a study which looked at ethical concerns perceived by the caregiver. When asked about other obligations (e.g., family or job) most respondents felt confronted with the moral dilemma regarding self-care (autonomy) and responsibility to self. Self-care and responsibility to self requires more than just attention to personal hygiene. Mental and physical health are essential to the individual's well being, especially to those individuals who are also responsible for the well being of others. In light of this, leisure and recreation services should be considered in any overall service plan designed to relieve caregiver burden.

As evidenced previously in the literature, leisure and recreation pursuits were identified as important to caregivers. Additionally, many studies noted the respondents' frustration over the loss of hobbies, social activities, exercise, and other leisure pursuits. Not one study, however, referred to leisure and recreation services as part of the proposed solutions for relieving stress of caregiver burden. For example, while Barusch (1988) reported that taking direct action was an effective coping strategy, specifically noting recreation and leisure examples given by respondents, the conclusions clearly omitted recreation and leisure services from proposed services.

Similarly, several studies identified constructive methods or actions to initiate relief for caregiver stress. For example, Pilisuk and Parks (1988) suggested eleven services that should be promoted and made more available to caregivers. These services, which included health care, community education, housing, transportation, mental health counseling, and family counseling also failed to note leisure services as an important part of the treatment plan.

Implications for recreation and leisure services cannot be ignored as contributing to the relief of

caregiver burden. Although leisure and recreation services cannot lift all of the burden of caregivers, they can help alleviate some of the perceived stress and strain of caregiving as well as help maintain the mental and physical health of the caregiver. Iso-Ahola (1980) cited many studies which conclude that continued recreation participation through one's entire life cycle contributes greatly to long and successful aging. Additionally, Iso-Ahola explored the important relationship between perceived freedom through leisure and one's well-being and how the threat of losing freedom can elicit a reactive behavior that can be detrimental. Unfortunately, as several studies indicate, many caregivers are probably not aware of their overall needs, much less leisure needs and therefore do not seek leisure services.

Program Needs for the Future

Many models and approaches of support services are outlined in the literature. Some are very clinical and many focus primarily on the care recipient, suggesting that positive changes in the care recipient might provide positive changes for the caregiver. Barusch (1988), however, challenged practitioners to design programs that would initiate and increase the use of services and social support by the caregivers themselves. Such programs must encourage caregivers to identify and seek help for their personal needs. Similarly, it is essential that this call for innovation and dedication include recreation and leisure services in its plea.

Zarit et al. (1980) endorsed a community support program that focused on the caregiver's well-being rather than on solutions to problems specific to caregivers situations. The two most common coping strategies were caregiver education and training for caregivers. Additionally, problem-solving has proved an important technique and needs to be included in training (Haley, Brown, & Levine, 1987). Sheehan and Nuttall (1988) noted that many programs focus on information and knowledge. However, attention needs be given to the emotional and affective elements within the caregiving situation as well.

It is important to note that inadequacy of services, rather than the wishes of the caregivers and recipients, is responsible for low use of services (Pilisuk & Parks, 1988). Caserta, Lund, Wright & Redburn (1987) sought to determine the need and the use of respite oriented services by caregivers. They found that lack of availability and access to these services are responsible for low use. The existence of awareness and access of services, however, do not always lead to use. Results also indicated that the main reason that caregivers do not use available services is the perceived lack of immediate need. With regard to recreation and leisure services, strong implications for leisure education exist.

Recommendations

The provision of recreation and leisure services must be incorporated into an interactive system with other services. Jennings (1987) proposed that a coordinated and accessible system of support for caregivers be established. Jennings also suggested providing information about services to potential and current caregivers. The barriers for service as noted above are not only the provision of services, which has been identified as quite meager, but also the utilization of these services by the caregivers themselves. Through networks and cooperative systems, services and information can be provided that can help caregivers understand the importance of recreation and leisure in their own lives.

Specifically, recreation and leisure services can address these unique needs in two basic ways. First, caregivers tend to ignore or dismiss their own needs, included recreation and leisure. Leisure education programs can address these needs and should be available to caregivers through cooperative community programs. For example, leisure education courses could be provided in community and municipal recreation programs. These classes would address such issues as assertiveness, leisure awareness, problem solving, decision-making, and empowerment for leisure pursuits. Other community services could incorporate recreation and leisure services as well. Women's centers and mental health services can easily incorporate leisure issues into their services. Outreach programs which include education for leisure and recreation brought into the homes can help caregivers realize not only the importance of leisure in their lives but also its role in relieving the caregiving burden.

Second, leisure services need to provide opportunities for caregivers to meet their identified recreational needs with innovative programs and opportunities both within the community and in the home. For example, skills courses, packets of

printed information, mobile units, and social networks must be considered to meet unique needs. These services could be incorporated into models like Couper's (1985) Family Dynamics Model, which helped identify sources of strain and conflict and included units on communication and logistical concerns. Similarly, Crossman's, London's and Berry's (1981) support group outreach model encouraged the caregivers to facilitate their own expression of feelings, and to discuss their social isolation, coping and problem solving issues. Both models could easily add and incorporate sessions addressing the need for recreation and leisure.

In conclusion, caregivers are a unique group of individuals who, through their care of others, sometimes ignore their own needs. Leisure and recreation activities and needs have been consistently identified in the literature as important but expendable facets of the caregivers' lives. Additionally, leisure and recreation activities have been identified as potential avenues for coping with caregiver burden. Unfortunately, the literature suggested nothing that includes leisure and recreation services as necessary parts of treatment or as viable strategies for the caregiver. This article has been an attempt to summarize the caregiver dilemma and is intended to initiate action toward cooperative and creative multifaceted programs which address the unique needs of caregivers in all areas of their lives, including leisure.

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Facilitating the Child's Adjustment to Parental Disability

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Abstract

The onset of a disability or chronic illness can be a traumatic and, at times, devastating experience for the entire family. Children are particularly vulnerable to the instability which often results from the necessary adjustments within the family. Programs are needed to assist the children of rehabilitation patients who are adjusting to, and coping with changes within their family. Parents frequently report changes in their children's behavior during the adjustment process such as withdrawal, depression, sleeping and eating disturbances, and *acting out* behavior. Long term challenges may include dealing with feelings of isolation, an ongoing need for age-appropriate information, and identification of appropriate roles for children. The *Sinai Kids Information Program for Rehabilitation (SKIP-R)* is an educational program designed to assist children in adjusting to and understanding a parent's disability. The program includes direct and indirect services to insure the systematic inclusion of children in the rehabilitation process. The program provides children between the ages of 6 and 14 years with the opportunity to: (a) lean about their parent's disability, (b) develop an understanding of how that disability or illness will impact on their family, (c) meet and nurture friendships with children in similar situations, and (d) assist children in identifying their role in the rehabilitation process.

The onset of a long term chronic disease or injury which results in permanent disability can be a traumatic and, at times, devastating experience for the entire family (Olsson, Rosenthal, Greninger, Pituch, & Metress, 1990). The children in the family are particularly vulnerable. Families frequently report dramatic changes in their children's behavior when a parent becomes disabled. These changes include withdrawal, depression, sleeping and eating disturbances, nightmares, and acting out behaviors. With the healthy parent's energy and attention focused on the patient during the rehabilitation process, children may feel forgotten or neglected. They are often left uninformed and confused about what has happened to their loved one. This confusion can lead to fear, anxiety and guilt (Fleming, 1987).

Children may also be faced with long-term challenges to their emotional adjustment. At times, children who have a disabled parent may feel painfully different from their peers. Missing or longing for the parent to be as he/she was before the disability is common. Children do not generally have the opportunity to meet older children who share similar concerns. These feelings of isolation may become amplified when the family does not appropriately address the subject of the disability within the home (Featherstone, 1980).

Children have an ongoing need for current and accurate information regarding the parent's disability and rehabilitation status. Often, families deny children access to information or fail to address their questions in an attempt to protect them from this painful situation. This lack of communication tends to increase children's apprehension and slow their

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adjustment to, and acceptance of the changes within their family (Meyer, Vadasy, Sewell, 1985).

Children often become confused about their role and may attempt to compensate for perceived changes in the physical and emotional functioning of the family. They begin to take on additional *adult* responsibilities and may try to fill the role of the disabled parent by doing household chores or providing care for younger children. In some families, a child may even become a caregiver to the disabled parent. Excessive responsibilities and pressure to achieve can quickly become an overwhelming burden for the child.

Traditional rehabilitation programs fail to systematically include children in the rehabilitation process. Families may feel reluctant to include their children in therapy sessions, family education, and patient related conferences. Furthermore, hospitals and rehabilitation centers are ill-equipped to provide the comfortable atmosphere needed to facilitate the inclusion of children (Fleming, 1987).

Identification of Need

A comprehensive literature search revealed little about children whose families are undergoing, or have undergone the rehabilitation process. The identification of need was based on: (a) direct observation of children in the rehabilitation setting; (b) patient and family input on the changes in their children's behavior following the onset of disability; and (c) the children's statements and questions reflecting general apprehension and lack of understanding.

Therefore, in response to the identified need of children within rehabilitation families, Therapeutic Recreation Services in the Department of Rehabilitation Medicine at Sinai Hospital developed an activity-based educational program called the *Sinai Kids Information Program--Rehabilitation (SKIP-R)*.

Program Objectives

SKIP-R is designed to assist children in adjusting to and understanding a parent's disability. The objectives of the program are as follows:

1. To provide children with accurate and age-appropriate information regarding their parent's disability,
2. To decrease the child's feelings of isolation through interaction with children in similar situations,
3. To provide parents with educational information and increase their awareness of factors affecting children throughout the rehabilitation process, and
4. To provide strategies to minimize the potential negative impact that a parental disability may have on the child's life and to identify the potential positive impact this experience can have on a child's growth and development.

Method

Over 150 children between the ages of 6 and 14 have participated in the *SKIP-R* program since its inception in 1987. Most of the children have a parent with a significant physical disability who was receiving or had recently received rehabilitation services. The parent's handicapping conditions included: multiple sclerosis, amputation, spinal cord injury, stroke, cancer and closed head injury. The children were identified through internal and external referral and a community outreach program for self referral.

Program Implementation

The program is organized by therapeutic recreation services and implemented with the support of the interdisciplinary team. An activity-based, age-appropriate curriculum is provided to the children by physical, occupational and speech therapies; audiology; nursing; and neuropsychology. Physicians interact with the children throughout the week to insure individualization of information regarding the medical implications of disability within each family.

Components of the program include one day seminars, a summer day camp, and family education services. The one day seminars are designed for children of recently disabled parents. They provide children with immediate access to information regarding their parent's unique situation. Information includes clarification of the vocabulary now being used within their home which may be as basic as *stroke*, *PT*, and *stump* or as threatening as *neuropsychology*, *aphasia*, and *chemotherapy*. Appropriate expectations including discharge plans are also included. The children are allowed the opportunity for hands-on experience with adapted equipment which will be utilized by their parent.

The day camp is an annual service held in the summer for five consecutive days. Children attend from 10:00 a.m. until 2:00 p.m. This week-long service allows the participating disciplines to provide more in-depth educational support to the children. It further allows therapeutic recreation staff the opportunity to identify and assess the individualized needs of each child. Assessment is primarily based on clinical observation, interviews, and parental input.

The average attendance at the summer day camp ranges from 30 to 40 children. The group is divided into smaller units of six to eight children based on age. Therapeutic recreation coordinates the master schedule and facilitates the smooth transition of groups from one activity or location to another. This often resembles the changing of classes at a local elementary or junior high school.

Therapeutic recreation also provides therapeutic play activities and social recreation experiences for the children. Therapeutic play activities include values clarification activities, psychotherapeutic games, puppetry, creative arts, and story improvisation. Social recreation experiences include physical activities, parties, entertainment, and unstructured sharing time. Together, these activities serve to encourage the establishment of healthy patterns of communication and to foster relationships between children.

Family education services are provided through written material and individual education sessions. Referrals are also made to community mental health services for families who need ongoing intervention. Additional community resources are explored through a variety of field trips in accordance with their individual needs. One of the more popular trips has been to local durable medical equipment suppliers to try out some of the adaptive equipment and liberating technology currently available.

The *SKIP-R* services are available free of charge to all participants. The cost of the program is minimal and requires only a few basic supplies; snacks; and the efforts, energies, and creativity of the rehabilitation staff. The program utilizes the hospital facilities, including physical, occupational and speech therapy treatment areas, two large conference rooms, and a multi-purpose auditorium, as well as the rehabilitation unit itself.

Program Evaluation

Ongoing program evaluation is implemented to monitor the effectiveness of the program. Focus is placed on quality improvement both programmatically and individually. Program evaluation includes pre- and post-tests and follow-up interviews.

Pre- and post-tests are completed by each child in the program. Questionnaires are completed independently by children who can read and write and privately with the assistance of a singular staff member by children who cannot. The questionnaires assess basic knowledge of parental disability, emotional response to the changes within their family, and direct feedback on the activities utilized in the curricula.

Follow-up telephone interviews are conducted with the children's parents one month after the program to evaluate its effects. Both parents are asked a series of questions designed to identify their perception of the impact of the program on the child's overall adjustment. Parents are asked to identify specific behavioral observations reflecting the child's ability to relate to and communicate with the disabled parent.

Results

Feedback from the parents of the children who participated in this program indicated a significant change in their children's attitude towards, and understanding of, the loved one's disability. Parents further noted improvement in their children's emotional acceptance of the change in their family life. However, they also identified a need for ongoing assistance. The children continued to express persistent feelings of isolation throughout the year. Follow up revealed that for many, camp was the only opportunity to meet friends in similar situations.

Pre- and post-tests were specific to the portion(s) of the program in which the child participated, therefore comparing results from the *Saturday Seminars* to the *Summer Day Camps* is not appropriate. However, a study in 1988 regarding program effectiveness reflected the following trend. The 1988 *SKIP-R* program sponsored a one-week summer day camp for 27 children between the ages of 7 and 14, 20 of whom participated in pre- and post-tests with the following results: feelings of

confusion regarding the disability of their family member were expressed by 95% in the pre-test, and 55% in the post-test; embarrassment about the disability was expressed by 70% in the pre-test, and 40% in the post-test; ability to explain the causes and effects of the disability improved in 75% of the children. One month follow-up telephone interviews with the parents revealed that 80% of the children demonstrated positive changes in their ability to relate to the disabled family member, 10% had no significant change, and 5% had increased withdrawal from the disabled family member (Mushett, Ellenberg & Hyman, 1989, p 78).

Conclusion

The immediate and long-term needs of many children with recently disabled parents are great. Therapeutic recreation professionals can play a significant role in facilitating the healthy adjustment of these children to the changes within their family. Therapeutic recreation services have long recognized the significance of the family network in positive outcomes. Therefore, the development and comprehensive implementation of activity-based programs for children is an appropriate expression of interdisciplinary family focused rehabilitation.

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Endnote

Additional information regarding the *SKIP-R* program is available from Renee Bleach-Hill at Sinai Hospital, Department of Rehabilitation Medicine, 6767 W. Outer Drive, Detroit, MI 48235.

The Interface Between Social and Clinical Psychology: Implications for Therapeutic Recreation

David R. Austin, Ph.D.

Abstract

A case is made for the application of knowledge from social psychology into clinical practice in therapeutic recreation. The historical relationship between social and clinical psychology that has lead to the interface between the fields is examined and assumptions underlying the interface are delineated. Work central to the interface is discussed including interpersonal processes related to the development and prevention of psychological difficulties, social processes in identifying and classifying psychological problems, and interpersonal processes involved with clinical interventions. Finally, implications for the interface are given for therapeutic recreation practice and a call is made for researchers and teachers to avail themselves of theory and knowledge resulting from the reunion of social and clinical psychology.

My advisor in graduate school, who was trained in social psychology, used to refer to those of us in therapeutic recreation as *applied social psychologists*. He perceived therapeutic recreation as a discipline that applied theories and research findings from social psychology to clinical practice, and, as a result of his urging, I chose social psychology as the cognate area for my Ph.D. work. This turned out to be an excellent choice as I was able to relate much of what I learned in social psychology to experiences I had gained as a practitioner in mental health. For instance, I was able to apply aggression theory from social psychology in my dissertation research. Aggression had been an area in which I had developed a great deal of interest while working as a therapeutic recreation specialist in a psychiatric hospital, so I was able to tie together social psychological theory and clinical practice.

Through my graduate study I came to understand what my advisor meant when referring to those of us in therapeutic recreation as *applied social psychologists*. There were a number of areas of social psychology that I found had direct implications for practice in therapeutic recreation. In addition to aggression, these areas included attribution theory, attitudes, locus of control, self-concept, self-actualization, social facilitation, the inverted-U effect, sensation seeking, need achievement, leadership, and group dynamics. It seemed that everywhere I turned there was information from social psychology relevant to the practice of therapeutic recreation.

Since that time and throughout nearly 20 years as a professor, however, I have had to work with a double handicap. Unfortunately, other than a few texts that have given limited coverage to social psychological concepts (e.g., Austin, 1982; Howe-Murphy & Charboneau, 1987; Kennedy, Austin & Smith, 1987), authors of therapeutic recreation texts have not integrated social psychology theory and research into the therapeutic recreation literature. Likewise, only a limited number of papers published in therapeutic recreation journals have drawn heavily on social psychological theory. To compound the problem, few social psychologists have related their field to clinical psychology, nor have clinical psychologists typically attempted to interface with social psychologists. Subsequently, there has been a lack of literature to borrow from social and clinical psychology that made a connection between academic social psychology and clinical practice.

The reasons for this lack appear to be obvious. First, therapeutic recreation itself is relatively new and is just building its body of literature. It is still

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defining itself and its relationship to other disciplines, including social psychology. Second, social psychology and clinical psychology traditionally have existed as two separate entities. There have historically been two types of approaches to interpersonal interactions, and, accordingly, social psychologists have developed one body of knowledge, while clinical psychologists have developed another. Although an occasional collaboration has occurred from time to time between these two disciplines, to a large extent they have existed independently.

Social psychology is a discipline that uses scientific methods to "understand and explain how the thoughts, feelings, and behaviors of individuals are influenced by the actual, imagined, or implied presence, of others" (Allport, 1985, p. 3). Much of clinical psychology similarly concerns the effects of social situations on the individual (Sheras & Worchel, 1979). Yet, despite the obvious shared area of interest, these two branches of psychology until recently remained separate. Why is this? An examination of their history reveals the answer to this question.

History of Social and Clinical Psychology

Social psychology is a relatively young field. The first social psychology experiment was done by Triplett in 1897, and the first social psychology text, by McDougall, was published in 1908 (Sheras & Worchel, 1979). But it was not until Kurt Lewin emerged in the late 1930s that the field achieved its own identity separate from sociology and psychology (Weyant, 1986). Known as the founder of social psychology, Lewin was an advocate for both basic and applied aspects of social psychology. Perhaps the best known quote in social psychology is that of Lewin who wrote that "nothing is so practical as a good theory" (Lewin, 1951, p. 169).

Even though the founder of social psychology believed that his field should research the pressing social problems of the day, interest in the practical application of social psychology was lost after Lewin's death. Weyant (1986) has written:

> Given that the discipline began with a strong bend toward practical applications, it may come as a surprise that after Lewin's death in 1947 social psychologists virtually abandoned real world problem-solving. Instead, they turned almost exclusively to laboratory research and set about developing and testing theories and principles. (p. 9)

It was not until the 1970s that social psychologists once more began to show interest in the application of their knowledge outside their laboratories. Due to an initial desire to test basic theories in natural settings, applied social psychology began to reemerge (Sheras & Worchel, 1979; Weyant, 1986).

Lightner Witmer, the founder of clinical psychology, began the first psychological clinic in American in 1896 at the University of Pennsylvania. Witmer also initially proposed the term clinical psychology for his new profession. As a charter member of the American Psychological Association, he recognized the need for a scientific basis for clinical practice. In 1908 Witmer published an extensive criticism of those in the mental health movement whom he felt were unscientific in their approach (McReynolds, 1987).

World War II had a tremendous impact on clinical psychology. It developed a very applied nature as psychologists attempted to treat those with battle-related psychological difficulties. Even though the field of clinical psychology adopted a *scientist-practitioner* model of professional preparation, the profession came to embrace an applied approach that emphasized clinical techniques and applications rather than research and theory development. By the 1950s, clinical psychology had separated itself from *pure* science. Only recently have clinical psychologists begun to recognize the value of research and theory in understanding the delivery of therapy (Leary & Maddux, 1987; Sheras & Worchel, 1979).

It is ironic that the two fields moved apart, because such separation is not in keeping with the views of their founders. Lewin urged his colleagues in social psychology to enter into exploration of real world problems only to have his discipline display little interest in practical applications and emphasize basic research. Witmer strongly believed in science as the basis for clinical psychology and yet clinical psychologists moved away from scientific research and the quantification found in social psychology (see Table 1). Though the two disciplines were joined together in the *Journal of Abnormal and Social Psychology* (*JASP*) in the 1920s, even pleas by noted psychologists Morton Prince and Floyd Allport could not keep the fields together. By 1965 *JASP* ceased production (Garfield & Bergin, 1986; Hill & Weary,

1983). Garfield and Bergin described the situation:

> During the early sixties, clinical psychologists appeared for the most part, to be sharply divided from their colleagues in social psychology. One group practiced psychotherapy; the other group conducted basic, theoretical research. One group read case studies; the other would consider results only from methodologically rigorous experiments. One group cared about the *real world*; the other seemed content to study college sophomores. (p. 70)

Things have changed markedly, however, for the disciplines of clinical and social psychology in recent years. With the arrival of the behavioral approach in the 1960s, clinical psychology became more concerned with empirical research and scientific methodology. At the same time, social psychology faced a *crisis* in which leaders questioned the reason for the existence of the field and urged greater concern for doing applied social psychology (Garfield & Bergin, 1986). Weary (1987) has further noted that there was a conceptual convergence of the two fields as social psychology began to focus more on cognitive processes. Additionally, Weary has stated that practical considerations, such as a tight job market and the necessity to do applied work in order to receive grants, may have influenced the coming together of the two groups. These influences, along with continuing pleas for unification from colleagues in both groups, brought social and clinical psychology together once more. In 1983 the *Journal of Social and Clinical Psychology* (*JSCP*) was created, "dedicated to work representing the rich and extensive interface of social and clinical psychology" (Harvey, 1983). A remarriage had occurred.

Publications that influenced the fields toward the interface included Brehm's (1976) *The Application of Social Psychology to Clinical Practice*, Goldstein's and Simonson's (1971) and Strong's (1978) chapters on an integrated approach in the *Handbook of Psychotherapy and Behavior Change*, and Weary's and Mirels' (1982) *Integration of Clinical and Social Psychology* (Brehm & Smith, 1986; Leary & Maddux, 1987). Since the publication of *JSCP*, Mark Leary has widely promoted the integration of social and clinical psychology through a number of publications including articles (Leary, 1987; Leary, Jenkins & Shepperd, 1984; Leary & Maddux, 1987) and the book, *Social Psychology and Dysfunctional Behavior: Origins, Diagnosis, and Treatment* (Leary & Miller, 1986). Also influential has been Brehm and Smith's (1986) chapter titled "Social Psychological Approaches to Psychotherapy and Behavior Change," in the *Handbook of Psychotherapy and Behavior Change*.

Underlying Assumptions

Assumptions that underlie the emerging interface between social and clinical psychology have been presented by Leary and Maddux (1987) and Maddux (1987). Maddux (1989, p. 96) has summarized this set of assumptions, which deal with the nature of psychological difficulties and their treatment (see Table 2).

To these assumptions Leary and Maddux (1987) provide two additional assumptions. One is that psychotherapy is first and foremost a social encounter whether done in a dyad or group. Their other assumption is that social psychological theories provide a foundation on which may be built models

Table 1
Fathers of Social and Clinical Psychology

Kurt Lewin, the founder of modern social psychology, was an advocate for practical applications of social psychology. Lewin believed social psychologists should study real-world problems.
Lightner Witmer, the founder of clinical psychology, recognized the need for a scientific basis for practice in clinical psychology. He criticized those in the mental health movement for being unscientific.

Sources: McReynolds, 1987; Weyant, 1986.

Table 2
Assumptions that Underlie the Interface

1. Psychological problems are essentially interpersonal or social problems that in many or most cases can be best defined and understood in terms of social cognitions and interpersonal behavior.
2. So-called normal social behavior--supposedly the subject of study of social psychology--is often maladaptive and dysfunctional (e.g., common errors in information processing and reasoning, inaccurate causal attributions).
3. The distinction between normality and abnormality is determined by social means and conventions.
4. Most effective clinical and counseling interviews target for change social norms and conventions.
5. Psychotherapy and counseling are essentially interpersonal encounters.
6. Clinical judgment and decision-making (e.g., diagnosis and assessment) are more similar to, than different from, everyday social perception, evaluation, and categorization.

for behavioral change. The overriding implicit assumption of those who work at the interface of social and clinical psychology would seem to be that problems in mental health (whether termed mental illness, psychopathology, emotional disturbance or whatever) are disturbances in interpersonal behavior that may be treated through an interpersonal enterprise.

Defining the Interface of Social and Clinical Psychology

Three categories or areas encompass work at the interface of social and clinical psychology according to Leary and Maddux (1987), Leary and Miller (1986) and Maddux (1989). These are social-dysgenic psychology, social-diagnostic psychology, and social-therapeutic psychology (see Table 3).

Social-Dysgenic Psychology. The social-dysgenic category is the study of interpersonal processes related to the development, maintenance, and prevention of psychological disorders. The notion underlying this category is that many psychological problems spring from interpersonal interactions and that most psychological problems involve human relationships. Social psychological phenomena related to this area are attribution, aggression, self--presentation, relationships, social comparison, conformity, the self, modeling, and roles. Specific topics under this category include: attributional models of stress, loneliness, and depression; self-presentation models of social anxiety, schizophrenia, and aggression; the role of social support in coping; problems associated with self-esteem maintenance; and self-efficacy models of avoidance and fear.

Social-Diagnostic Psychology. The concern of the second category, social-diagnostic psychology, is with the role of social processes in identifying and classifying psychological problems. The idea underlying this category is that social inference is involved in the identification and classification of psychological problems. Person perception, judgment heuristics, attribution, labeling, inferential biases, and conformity are social psychological phenomena related to this second category. Specific topics that may fall under this area include: effects of psychologists' theoretical orientations on perceptions and analyses of data, effects of labeling clients on subsequent diagnosis, and choices clinicians make to test their preconceptions about clients.

Social-Therapeutic Psychology. The final category of social-therapeutic psychology deals with interpersonal processes associated with clinical interventions. Social psychological phenomena related to this area are attitudes, social influence and power, resistance to influence, interpersonal attraction, group dynamics, self-fulfilling prophecies, cognitive dissonance, the self, modeling, and relationships. Examples of specific topics under this category related to treatment include: effects of

Table 3
Categories at the Interface

1. *Social-Dysgenic Psychology*. Deals with social processes related to the development, maintenance, and prevention of psychological disorders.

2. *Social-Diagnostic Psychology*. Deals with social processes related to the identification and classification of psychological problems.

3. *Social-Therapeutic Psychology*. Deals with social processes associated with clinical intervention programs.

Sources: Leary & Maddux (1987), Leary & Miller (1986), Maddux (1989)

therapist characteristics and behaviors on treatment outcomes, attitude change in therapy, expectancy effects in treatment, self efficacy in behavioral change, effects of social support on treatment outcomes, therapist-client relationship, and effects of loss of control (Leary & Maddux, 1987; Leary & Miller, 1986).

Brehm and Smith (1986) have completed an extensive review of social-therapeutic psychology from three perspectives. These are, respectively, the social psychology of the therapist, the client, and the therapy. Topics under the heading of the therapist include those such as therapist beliefs about mental health, interpersonal judgments, attributions to dispositional cause, and stress and burnout among therapists. Concerns related to the client include effects of social support, effects of positive outcomes, attributions and depression, self-concept, self-awareness, self-handicapping, and person perception. Under the third and final heading, Brehm and Smith (1986) review studies related to topics such as choice and control, paradoxical interventions and reactance, misattributions, and causal attributions.

Other authors have likewise explored the social psychology of clinical interventions. Harari (1983) has, for example, discussed six topics as clinical techniques that have roots in social psychology: screening and diagnosis, role playing, cognitive balance testing, attitude changes, group dynamics, and reverse placebo therapy (i.e., telling clients the placebo would aggravate their condition). Spring, Chiodo and Bowen (1987) have discussed perceptions of social and personal space and sense of control as areas of concern for the interface of social and clinical psychology. Weyant (1986) has discussed three treatment approaches based on social psychology. These are: vicarious extinction (based on social learning theory), effort justification (based on cognitive dissonance theory), and attribution therapy (based on attribution theory).

In introducing the *Journal of Social and Clinical Psychology* in the inaugural issue, Harvey (1983) listed a number of topics to illustrate those appropriate for the new journal including: close relationships, helplessness and perceived control, social skills, attributions and labeling of mental illness, client-therapist interactions, social aspects of judgments of psychopathology, compliance with medical regimens, beliefs about the nature of mental illness, sex differences in mental disorders, and broad clinical issues such as de-institutionalization and mainstreaming.

A final means of defining the interface between social and clinical psychology is to examine chapters in major works dealing with the interface. *Social Processes in Clinical and Counseling Psychology* by Maddux, Stoltenberg and Rosenwein (1987) has chapters that cover social support, self-efficacy theory, counseling and persuasion, social influence, social comparison and depression, self-handicapping, social anxiety, and attributional approaches. Chapters in Leary and Miller's (1986) *Social Psychology and Dysfunctional Behavior* include: attributional processes; attributions, perceived control, and depression; self-processes; self-presentation; anxiety and inhibition in interpersonal relations; troubled relationships; clinical inference; social influence; behavioral compliance; and expectancy theory.

As Weary (1987) and Maddux (1989) have commented, the flow of information at the interface

has largely been in one direction. It is clear that the direction has been from social psychology to clinical psychology at this point.

Implications for Therapeutic Recreation

On a practical level, one obvious implication resulting from the interface of social and clinical psychology is that a body of literature is beginning to form from which therapeutic recreation may borrow. For instance, Leary and Miller's (1986) book, *Social Psychology and Dysfunctional Behavior: Origins, Diagnosis, and Treatment*, has served as an excellent source of readings for students in my course on the social psychology of therapeutic recreation.

But, one may ask, what specific things can therapeutic recreation derive from the work of those doing research at the interface of social and clinical psychology? Two areas emerge as ones from which therapeutic recreation can gain a great deal. One is understanding dynamics that relate to the development and treatment of psychological problems. A second deals with social-therapeutic processes involved with providing interventions. Within this second area fall such concerns as client-therapist relationships, personal space and touch, leadership and power, and group dynamics. While not dealt with to the extent that they could be, topics within this second area traditionally have been given at least minimal attention in the therapeutic recreation literature. It is the first group of topics that generally has not been given coverage. In the interest of space and because it has been so neglected, only this first area related to understanding the development and treatment of psychological problems will be reviewed within this paper.

In order to provide treatment, therapists must understand the dynamics surrounding the client's problem. Austin (in press) has drawn on the literature of social-clinical psychology to provide understandings for therapeutic recreation specialists of interpersonal processes involved with such social psychological concepts as self-concept, learned helplessness, the self-fulfilling prophecy, labeling, loneliness, self-efficacy, and attributional processes. While not inclusive, these topics represent highly useful areas of information and understandings for therapeutic recreation specialists. A brief discussion of each of these topics follows, together with a brief case study to illustrate clinical application of the concept.

Self-Concept. Self-concept can be a pervasive factor in determining behavior. If we see ourselves as highly competent, we are much more likely to take risks and enter into new behaviors. On the other hand, if we perceive ourselves to lack competence, our feeling of inadequacy can be debilitating (Iso-Ahola, 1980). Self-concepts are gained through our experiences, including evaluations from others, social comparisons, role playing, and perceptions of being distinctive from others (Gergen & Gergen, 1986).

The affective part of self-concept, our self-esteem or how we regard ourselves, is developed through these same mechanisms. Knowledge of the dynamics upon which self-esteem rests may be extremely helpful to understanding the etiology of client problems and how these problems may be approached through treatment. For instance, unhealthy behaviors can arise as clients attempt to protect self-esteem through self-handicapping. In self-handicapping, people actually arrange impediments that they can later blame for their failures. They self-handicap themselves so they will have excuses if they do not succeed. An example would be *pulling an all-nighter* before an examination so any failure could be blamed on a lack of sleep. A more serious example might be taking drugs before an important life occurrence in order to blame any possible negative outcome on the debilitating effects of the drug (Leary & Miller, 1986).

Realizing that clients may engage in self-handicapping can be important information for therapeutic recreation specialists. For example, when clients do not give their best effort, therapeutic recreation specialists may recognize that clients are engaging in self-handicapping to save face should they fail. Such clients may need extra support in order to do their best. Knowing the dynamics of self-handicapping helps therapeutic recreation specialists understand clients' behaviors and provide means to assist clients with more adaptive ways to cope.

> Jim, an adolescent being treated for psychological problems, did not freely participate in volleyball games, choosing to *blow-off* the activity. It became clear during group processing, following a volleyball game, that Jim was trying to *save face* by not

appearing to take the activity seriously. Self-handicapping was being used by Jim to avoid embarrassment for what he perceived to be an inadequate ability level due to his self-concept of being physically weak when compared to his muscularly stronger peers. With the help of the therapeutic recreation specialist and others in the group he became aware of his behavior and decided to enter into a program to increase his muscular strength so he could feel more comfortable about his self-image and enhance his physical abilities.

Learned Helplessness. We humans strive for control over ourselves and our environments (Grzelak, 1985). Research has shown that experiencing a lack of control over aversive situations can produce a sense of uncontrolability (Leary & Miller, 1986). Repeated failure to exercise control can create feelings that an individual is helpless to control his or her environment (Iso-Ahola, 1980). This can create a debilitating effect, termed learned helplessness, that can lead to the development of apathy, depression, and withdrawal. In extreme cases, even death may result due to the perceived uncontrolability of a stressful situation (Gatchel, 1980).

In light of this, it is tragic that the environments of many institutions, hospitals and other health care facilities bring about feelings of helplessness. The recognition, by therapeutic recreation specialists, that helplessness can be a problem for clients and may cause depression can be helpful to planning interventions for those suffering from learned helplessness and to preventing the occurrence of helplessness within the health care setting. Clients can become involved in activities that allow them to master challenges and learn to endure frustration. Recreation can provide a means to exercise control within the health care environment.

Mary, a patient in the admission unit of a state psychiatric hospital, felt helpless. It seemed she had little control over her life. "No matter what I do, I can't change anything," Mary exclaimed. Learning of Mary's feeling of helplessness, the therapeutic recreation specialist began to work with Mary to increase her perceived control and provide opportunities to achieve mastery over her environment.

Self-Fulfilling Prophecy. The self-fulfilling prophecy is sometimes referred to as the self-fulfilling expectation. By others, it is referred to as the Pygmalion effect after the Greek sculptor whose statue of a beautiful woman came alive due to his expectations (Gergen & Gergen, 1986). By whatever name, this phenomenon deals with what happens to persons as a result of the expectations others hold about them. The most well known study of self-fulfilling prophecy is the now classic *spurters' study* by Rosenthal and Jacobson (1968). In this study, students thought to be especially prone to achieve (i.e., *spurters*) were shown to outperform their peers at the end of the school year. While the attribute of being a *spurter* was randomly assigned, the teachers' expectations and ensuing actions produced the outcomes they had expected. This study and others established what can happen to persons due to others' expectations. In the Rosenthal and Jacobson study the outcome was a happy one (at least for the *spurters*) but negative expectations can similarly have an effect on others. Therapeutic recreation specialists need to be aware of the effect that prejudices or preformed expectations may have on clients.

Staff in a camp for children with disabilities were observed to be giving minimal feedback to campers who were generally not successful in their performance during activities. It was discovered that staff did not believe that the campers could succeed due to the severity of their disabilities. With training, the staff came to understand their self-fulfilling expectations and began to provide encouragement and corrective feedback to the campers who were able to achieve at a much higher level than had been anticipated before staff became aware of their self-fulfilling expectations.

Labeling. Labeling individuals can result in having them being perceived in a certain way, rather than being appreciated for their unique characteristics. For example, an individual who is labeled *mentally ill* may be perceived as a person possessing negative traits. Whether or not the label is valid, labeling a person can affect others' responses to the individual (Austin, 1982). The effects can be damaging if staff devalue the person due to a diagnostic label to which they have connected

negative connotations. It is important for therapeutic recreation specialists to understand how harmful the labeling of clients by others can be and to avoid stereotyping clients themselves.

> Michael, a therapeutic recreation student intern, initially attempted to apply his learning from his abnormal psychology class during his psychiatric internship. He soon discovered how unreliable diagnostic labels can be, even though assigned by medical experts. In a meeting with his clinical supervisor, Michael revealed that he had found that diagnostic labels could limit his perceptions of clients and that he would be cautious not to perceive the person purely as a diagnostic label.

Loneliness. Lonely individuals do not have their expectations for social relationships filled. They feel deprived of intimate relationships with others. Ensuing despair, dejection, and depression may be felt by those who experience loneliness (Perko & Kreigh, 1988; Shultz, 1988). Those who are lonely often hold negative perceptions of themselves and others, exhibit social skills deficits, are more superficial and inhibited, and are less intimate than others (Leary & Miller, 1986).

All of these traits of lonely persons have implications for transactions that therapeutic recreation specialists have with clients who experience feelings of loneliness. It is important for therapeutic recreation specialists to understand the dynamics of loneliness because treatment will necessarily have to be concerned with negative outlooks, social skill deficits, and superficial functioning due to taking few social risks. Trust building with those clients who are lonely becomes an important first step for therapeutic recreation specialists to take.

> Joe, a 20 year old man with mild mental retardation, felt lonely and depressed. He told the therapeutic recreation specialist he did not know how to make friends. Joe and his therapist decided social skills training would be helpful to the solving of this problem. Joe was able to overcome his social skills deficiencies after several months of social skills training classes. He began to make friends and feel better about himself.

Self-efficacy. According to Bandura's (1986) self-efficacy theory, self-referent thoughts play a central role in mediating behavioral change. Clients' efficacy judgments (i.e., their personal evaluations of their abilities) have a direct effect on how they cope with their problems according to self-efficacy theory. Client expectations about themselves greatly influence their approach to problems. Clients who are self-doubters will generally have limited confidence in their abilities, will have little willingness to cope with problems, will put forth a minimal effort, and will give up easily. In contrast, those with high efficacy will likely meet their difficulties and exert maximum effort, even in the face of adversity (Leary & Miller, 1986). It is therefore critical that therapeutic recreation specialists understand self-efficacy theory and the means by which efficacy judgments are developed and altered.

> Judi wished to take control over her life but lacked confidence in her abilities. She decided to do something about her perceived problem. She became involved in an adventure challenge therapy group as a part of her treatment program. Following her successful participation in the group, she experienced renewed confidence in her ability to direct her life.

Attributional Processes. Attribution theory deals with the processes through which we infer causes for events from our observations. Attributional processes explain the events that occur in our lives. Such explanations have significant psychological consequences because our reactions to emotional events, our self-esteem, our judgments about ourselves and others, and our expectations about the future are all subject to the influences of our causal attributions (Leary & Miller, 1986). Such are the ramifications of attributional processes for understanding psychological problems and treating them that at least one entire book has been devoted to the topic, *Attribution Theory in Clinical Psychology* by Forsterling (1988). Attribution theory assists us in understanding cognitive determinants of psychological disorders such as anger and depression and allows us to derive therapeutic techniques from attribution research (Forsterling, 1988).

> Bonni did not believe she could *make it* outside the hospital. While her job would offer

structure and security during the work hours, she did not feel she had the social skills to enjoy her leisure time. The therapeutic recreation specialist suggested that Bonni might benefit from a leisure counseling group. Based on information provided by others during counseling sessions, Bonni was able to understand that she was making unrealistic attributions and that she did have the ability to succeed in her leisure pursuits.

Conclusion

The disciplines of social psychology and clinical psychology have recently acknowledged their joint concern for interpersonal processes that affect people. After many years of separation, these two fields have shown that a theory-based, academic discipline and a practice-based, real world discipline can complement and gain from one another. The implications of the marriage of social and clinical psychology for therapeutic recreation are far reaching. Knowledge from the interface of these disciplines provides theory for research and knowledge for practice for therapeutic recreation specialists who may be perceived to be *applied social psychologists* as they apply information from social psychology in clinical practice.

The focus of this paper has been on the interface of social and clinical psychology and its relevance for practice in therapeutic recreation. While it could be inferred that the understandings from the described interface deal exclusively with severe psychiatric problems, this is not the case. Most of the social psychological concepts that have been discussed within this paper have application with diverse populations within a variety of clinical settings. Therapeutic recreation specialists working with any special population, including persons who are developmentally disabled, physically disabled, or elderly, can profit form the remarriage of social and clinical psychology.

Within this paper, I have argued for the value of the interface of social and clinical psychology for therapeutic recreation. It is my hope that researchers and authors in therapeutic recreation will begin to avail themselves of theories and information resulting from the reunion of social and clinical psychology. Further, I would call on educators to expose their students to the literature at the interface. There is a wealth of new information now available to therapeutic recreation. Let us have the foresight to improve practice within therapeutic recreation by taking advantage of the emerging field of social-clinical psychology.

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Relationships Between Meanings of Work and Meanings of Leisure Among Wheelchair (Basketball) Athletes

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Abstract

The purpose of this study was to examine related meanings of work and leisure as they were perceived by a random sample of 200 disabled adults (N=124) who were chosen from the National Wheelchair Basketball Association's team rosters. The theoretical base of research in the area of work-leisure relationships lies in the evaluation of the tenability of two rival hypotheses that attempt to describe the relationship between meanings of work and meanings of leisure. The compensatory hypothesis suggests that an individual will select leisure activities which compensate for deprivations experienced in the work setting. In contrast, the spillover hypothesis argues that meanings derived from the work environment will simply spill over into the leisure domain. In order to examine the meanings of work and leisure along a common scale of measurement, a semantic differential instrument, the Work Leisure Attitude Inventory (WLAI) (Hunt, 1979) was utilized. The WLAI consists of 11 evaluative bipolar adjective scales designed to rate 13 concepts identified by Havighurst (1957) as important aspects of the work and leisure domains. The results of the Pearson product-moment coefficients of correlation calculated for each of the 13 work-leisure concepts indicated that there were significant ($p \leq .05$) positive correlations between three of the 13 concepts. Results also suggested that this sample of wheelchair athletes perceived both their work and their leisure experiences as *meaningful*, as evidenced by the finding that 12 of the 13 concepts statements received positive ratings in both the work and leisure domains. Assuming that the perceptions of the individual are a valid data source in occupational and leisure planning, the information provided by this study could be utilized in developing strategies for the future realization of favorable work and leisure meanings on behalf of disabled persons.

Work-Leisure Theory

Work and leisure represent major life segments from which individuals derive considerable psychological meaning. While the psychological meanings of work have been consistently explored via numerous types of job satisfaction studies (Friedmann & Havighurst, 1954; Morse & Weiss, 1955; Orzack, 1963; Berger, 1964; Tausky, 1969), considerably less attention has been given to the psychological aspects of leisure (Neulinger, 1971) or the psychological aspects of the work-leisure relationship.

Most researchers concerned with work and occupation agree that the concept of meaning overlaps that of satisfaction. Parker (1971, p.49) asserted that when an individual finds work satisfying, "This is a way of saying that work has meaning for him, that he can see the purpose for which it is done and that he agrees with the purpose." Although meanings of work vary according to the specific job context and the particular personality of the worker, findings in this area have basically agreed on several key points.

The professional and upper echelon workers generally value work highly not only for economic benefits but also for the self-identification and prestige provided by a respectable job (Friedmann & Havighurst, 1954: Morse & Weiss, 1955; Orzack, 1963). Distinctions between work and leisure patterns of professional people were found to be unclear in that much of the work for this group may also be considered as leisure. Workers in occupations which permit neither social standing nor

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making a living, and their job was often seen as a direct threat to self-identification (Blauner, 1964; Tausky, 1969). Perhaps the large bulk of both white-collar and the blue-collar workers could be classified in a third group that neither rejoices nor suffers in work but puts up with it more or less for the sake of other things (Berger, 1964).

One of the major problems confronted in studying the meaning of leisure is the fact that there exists no one consistent definition of the subject (Ennis, 1968; Neulinger, 1971). Most of the published research in the area of leisure has dealt with leisure activities, leisure expenditures of time and money, or leisure definitions, rather than with the social-psychological aspects of leisure (Neulinger, 1971). Of those studies focusing upon the psychological aspects of leisure, the majority have viewed leisure in relation to some aspect of work (Kelly, 1972; Neulinger, 1971; Spreitzer & Snyder, 1974: Hunt, 1979; Iso-Ahola, 1979).

Havighurst (1961) asserted that the psychological meanings of leisure are also the psychological meanings of work, but a strict comparison is not possible due to the difficulty in making exact quantitative comparisons. Kando (1975) delineated at least two possible approaches to relating work and leisure: to correlate specific occupations with specific forms of leisure, and compare the meanings and functions of leisure and work.

Zuzanek and Mannell (1983) suggested that empirical studies examining the work-leisure relationship vary in terms of the way in which they operationalize work and leisure. Most classic work-leisure conceptualizations examined the effects of work structure--complexity, amount of supervision, opportunities for personal interaction, and degree of autonomy--on leisure behavior. However, many researchers have advocated that it is not the work structure but rather the socially internalized attitudes and meanings associated with work which affect leisure participation (Kando & Summers, 1971). Studies supporting this view have often concentrated on correlations between work-leisure meanings.

This pervasive influence of work into the non-work domain was described by Wilensky (1960) in terms of two general hypothetical formulations, compensatory and spillover. The compensatory hypothesis suggests that workers who experience deprivation at work will compensate for this deficiency by becoming involved in more gratifying non-work activities. Spillover signifies that leisure activity may be influenced by characteristics that have spilled over from work.

According to Zuzanek and Mannell (1983) several tentative generalizations can be made about the nature of the empirical support for the spillover and compensatory conceptualizations of the work-leisure relationship, these include the following: the spillover relationship appears to be stronger for workers who perceive work as being important to them. There is little support behaviorally for compensation, but it does have some support when attitudes are assessed and people's rationalizations for why they get involved in various leisure activities are considered. The types of relationships between work and leisure vary among different groups of people. Finally, there is no unequivocal support for either of the two work-leisure hypotheses.

Several studies have investigated certain aspects of the leisure-work relationship within the framework of compensation and spillover (Spreitzer & Snyder, 1974; Shepard, 1974; Hunt, 1979; Hunt & Brooks, 1980). Within the context of the compensatory hypothesis, Spreitzer and Snyder (1974) explored the relationship between work orientation and the subjective meanings assigned to leisure activities by 510 urban dwellers. Findings strongly supported the compensatory hypothesis that persons lacking intrinsic involvement with their jobs were more likely to define leisure activities as means of self-identity. Multiple indicators of leisure meaning revealed a definite relationship to work orientation.

Shepard (1974), based on the notions of compensation and spillover, proposed a theoretical model of work-leisure relationships within the context of the selected social-psychological variables. These variables include self-evaluation, status recognition, and alienation. Shepard theorized that persons who cannot maintain a favorable self-evaluation during work activities will engage in non-work activities that will provide positive feedback for self. Similarly, persons who are denied opportunities for status recognition at work will attempt to engage in status-giving activities outside of work to avoid low self-esteem. With respect to the spillover leisure hypothesis, a complete lack of opportunity for status recognition at work will cause persons not to attempt to gain status recognition outside of work, thus assuming that work has over-riding social-psychological effects.

Hunt (1979) investigated the relationship between the subjective meanings of work and leisure among a sample of 133 university employees comprising three different occupational classifications. Significant positive correlations were found to exist between the meanings of work and meanings of leisure in each of the three occupational groups, indicating a spillover effect. Significant differences were found in the way in which the three occupational groups conceptualized the meanings of work.

Hunt and Brooks (1980) studied the relationship between the subjective meanings of work and leisure among a sample of 71 industrial employees comprising two occupational groups. Findings indicated a spillover effect independent of sex or occupational group.

In examining the relevance of the compensatory and spillover hypotheses for the study of leisure behavior, Kando and Summers (1971) identified three problem areas which interfere with the development of a theory of work-leisure. The first problem area has been the failure to isolate the work-leisure relationship from other impacting demographic variables such as sex, education and occupation. A second problem area has been the failure to distinguish between meanings of work and leisure, and forms of work and leisure. A third problem has been the failure to specify the conditions under which the spillover and compensation occur.

The Physically Disabled in the Work Setting

The vast majority of studies that investigate the role of the physically handicapped in the work setting concentrate on barriers to employment faced by the disabled and the degree of acceptance of the disabled by their able-bodied fellow workers (Krafting and Brief, 1976; Rose and Brief, 1979; Siegfried and Toner, 1981). Very few studies have asked the physically disabled to reflect on the meanings that they attach to work.

In 1982 Florian identified three primary factors in the meaning of work for a group of physically disabled rehabilitation clients: social contact, self-image, and financial-economic. Among the three factors, the clients indicated that social contact was the most important to them. In a later study Florian and Har-Even (1984) investigated the meanings of work for three groups undergoing rehabilitation. The groups included clients with schizophrenic diagnoses, depressive diagnoses, or physical disabilities, and a control group of non-disabled participants. Once again, the profiles of factor scores revealed that those subjects with physical disabilities rated social mastery as the most important factor.

Bolton (1980) conducted an item factor analysis of the 45 items of the Work Values Inventory (WVI) for 445 physically disabled clients. The WVI was designed to assess the range of values that influence the motivation to work. This item factor analysis produced six major dimensions that described this physically disabled population's motivation to work including stimulating work, interpersonal satisfaction, economic security, responsible autonomy, comfortable existence and aesthetic concerns. The six factors were found to be virtually independent of age, education and intelligence.

There is little doubt that *work* represents a major focus of life for most adults. In addition to enabling one to earn a living the job provides one with challenge and an opportunity to do something worthwhile. Of perhaps equal importance is the social context of work in which one invariably comes into contact with many different people. Often some of these relationships become significant ones which may extend far beyond the work place. In many instances, however, the socializing that the handicapped individual experiences at work does not always extend past the work place. Sandys and Leaker (1987) suggest that transportation problems, lesser income levels, variations in personality, and lack of experience are all factors that affect the ongoing process of leisure integration for the disabled.

Participation by Physically Disabled in Wheelchair Sports

Since their beginning in Veteran's Administration Hospitals in the mid-1940s, wheelchair sports have acquired a substantial following of professionals who believe that they are a means to enhance the self-esteem and self-perceptions of competence of physically disabled participants (Guttmann, 1976; Labanowich, 1978; Madorsky and Kiley, 1984). This relationship between wheelchair sport engagement and positive psychological change has been examined (Szyman, 1979; Patrick, 1984; Robinson, 1985; Hendrick, 1985) with findings that differ in the degree to which they support the strength of this relationship. For example, Szyman (1979) reported that his investigation of a sample of

physically disabled college students revealed no support for a causal relationship between wheelchair sport participation and self esteem. Hendrick's (1985) investigation of the effect of participation in an instructional wheelchair tennis program upon physically disabled adolescents' self-perceptions of their own general cognitive, social and physical competence found that participation in wheelchair tennis can significantly improve the disabled adolescent's general perceptions of his or her physical competence. Patrick (1986) measured ten novice mobility impaired athletes prior to, and five months after, their first competitive wheelchair experience. He compared them to veteran athletes and non-athletes on issues of self-concept and acceptance of disability. He found that, as an effect of the athletic participation, significant gains were made regarding self-concept and on sub-scales of perceived behavior, family self, as well as acceptance of disability.

This review of literature has highlighted research in the area of work-leisure theory, because the theoretical direction of the study's research question is so grounded. The meanings that the physically disabled assign to their work and leisure, and the effect that participation in wheelchair sports has on the wheelchair athlete have been discussed to better describe the unique population from which the subjects of this study were selected. It appears that numerous studies which focus on the integration of the physically disabled into both the work and leisure settings have been conducted. However, a paucity of research still exists in the area of meanings that the physically disabled attribute to their work and leisure.

In this regard, the study sought to determine the relationship between the meanings of work and leisure among physically disabled wheelchair basketball players within the framework of the compensatory and spillover hypotheses. The significance of the study lies in its attempt to examine a unique population in a continued effort to shed light on the work-leisure relationship as well as to provide exploratory data concerning the subjective meanings assigned to work and leisure by a population of athletes with physical disabilities.

Methodology

Sample Description

With the cooperation and approval of the National Wheelchair Basketball Association (NWBA) Commissioner's office, a random sample of 200 players was selected from the NWBA team rosters. All 200 players were mailed a questionnaire consisting of a cover letter which endorsed the study, the actual instrument and questions regarding demographic data. The respondents were assured anonymity and asked to return the completed questionnaire to the researcher within two weeks. Those not returning the original questionnaire were sent a second questionnaire which again asked for their cooperation. As a result of the initial mailing and the follow-up a total of 124 athletes submitted a completed questionnaire.

All subjects were physically disabled as evidenced by the fact that they were eligible to participate in the NWBA, but they were not asked to record the level of their disability. The sample included 117 males and seven females. The vast majority of the sample (77%) were between 25 and 44 years of age. More than half of the sample (55%) reported that they were married. Only 6% of the sample had never been employed on a full-time basis, and 64% of the sample reported a family income of $15,000 or more with a majority (62%) reporting their occupational classification as managerial/self-employed or professional. While this random sample should be representative of those athletes participating in the NWBA, it may not be overly representative of the physically disabled in general.

Data Collection

Data concerning the meanings of work and leisure were collected via the use of a survey questionnaire. To examine the meanings of work and leisure along a common scale of measurement, a semantic differential instrument, the Work-Leisure Attitude Inventory (WLAI) (Hunt, 1979) was utilized (Figure 1). Subjects were asked to respond to 13 work concepts and to respond to the same 13 concepts in their leisure-based lives. For purposes of this study *work* was defined as the occupational position held by an individual for which he/she receives a paid salary. *Leisure* was defined as the sum total of all experiences within one's life that he/she personally perceives to be leisure.

The WLAI consists of 11 evaluative bipolar adjective scales designed to rate 13 concepts identified by Havighurst (1957) as important aspects of the work and leisure domains. The adjective

Figure 1. Concept statements and bipolar adjective scales of the Work-Leisure Attitude Inventory.

1. When I am at work/leisure I feel the following ways about myself.
2. When I am at work/leisure I feel the freedom I experience is:
3. When I am at work/leisure I feel that my opportunity to experience creative behavior is:
4. I feel the following ways about time-killing activity in my work/leisure:
5. When I am at work/leisure I feel that the opportunity for development of my talent is:
6. When I am at work/leisure I feel the following ways about the amount of physical energy that I must use:
7. In my work/leisure I feel that my opportunity to serve others is:
8. In my work/leisure I feel that the status (or social position) that I occupy is:
9. When I am at work/leisure I feel that my opportunity to relax from tension is:
10. When I am at work/leisure I feel that the social relationships that I experience are:
11. When I am at work/leisure I feel that my opportunity for new experience is:
12. When I am at work/leisure I feel that the competition that I experience is:
13. In my work/leisure I feel that my opportunity for leadership is:

Bipolar Adjective Scales*

1. Valuable	___:___:___:___:___:___:___:	Worthless
2. Unpleasant	___:___:___:___:___:___:___:	Pleasant
3. Important	___:___:___:___:___:___:___:	Unimportant
4. Boring	___:___:___:___:___:___:___:	Uninteresting
5. Frustrating	___:___:___:___:___:___:___:	Satisfying
6. Desirable	___:___:___:___:___:___:___:	Undesirable
7. Meaningless	___:___:___:___:___:___:___:	Meaningful
8. Bad	___:___:___:___:___:___:___:	Good
9. Beneficial	___:___:___:___:___:___:___:	Harmful
10. Fun	___:___:___:___:___:___:___:	Not Fun
11. Frequent	___:___:___:___:___:___:___:	Not Frequent

* All 13 concepts were scored for work, and then they were all scored for leisure.

scales were developed through factor analysis and piloted for purposes of reliability. The Cronback alpha internal consistency scores for each of the concepts in both the work and leisure domains indicated that the lowest reliability for any of the 26 concept statements was .90.

Each page of the WLAI contained a concept statement followed by bipolar scales on which the direction and intensity of reaction to the statement were indicated. The instrument yielded two scores for each concept statement, a work score and a leisure score. For purposes of scoring consistency, the unfavorable pole of each scale was uniformly assigned the score of 1, and the favorable pole of each scale was assigned the score of 7; then the attitude score was obtained by merely summing over all ratings. The possible range of scores for any one concept was 11 to 77. A score of 11 would indicate that all terms representing a particular concept statement were rated 1, or the lowest possible score. A score of 77 would indicate that all items were rated 7, the highest possible score. A score of 44 would indicate that the mean on ratings for that concept was 4, or neutral. This instrument has been used in previous studies with industrial employees (Hunt & Brooks, 1980), retired individuals (Hunt and Weiner, 1982) and unemployed adults (Hunt, 1985).

Results

Overall respondents perceived the majority of the work-leisure concept statements favorably. Mean scores on 12 of the 13 concepts were above the neutral point (neutral point = 4) on each scale. The concept *time-killing activity* was the only one to receive a less than neutral score, thus indicating that respondents did not perceive the notion of wasting time in either work or leisure as a favorable concept. A summary of the mean scores for the respondents appears in Table 1.

Table 1
Summary of Mean Scores for Work-Leisure Concepts

Work-Leisure Concepts	Subjects	
	Work	Leisure
1. Myself	5.53	6.03
2. Freedom	5.50	6.46
3. Creative Behavior	5.49	6.13
4. Time-Killing Activity	2.60	3.02
5. Development of Talent	5.52	6.07
6. Physical Energy Input	4.57	6.40
7. Service to Others	5.86	6.10
8. Status	4.66	5.61
9. Relaxation from Tension	5.44	6.26
10. Social Relationships	6.15	6.47
11. New Experiences	5.36	6.11
12. Competition	4.73	6.23
13. Leadership	5.32	5.89

Mean scores are based on individual responses to a semantic differential rating each work-leisure statement from a low score of 1 to a high score of 7.

In order to determine whether a significant relationship existed between scores on work and leisure concepts, Pearson's product-moment coefficients of correlation were calculated for the 13 work-leisure concepts. Table 2 presents the coefficients of correlation.

Among the respondents three of the 13 concepts were significantly ($p \leq .05$) similar for both the work and leisure domains with the absolute values ranging from $r = .19$ to $r = .70$. Because a common instrument was utilized to measure both work and leisure attitudes, there is undoubtedly some common methods variance in the correlations between the work and leisure responses. Also, the r of .19 is rather low and reaches significance primarily because of the large sample N's. Therefore, it would seem best to interpret the r's rather conservatively.

Table 2
Summary of Correlation Coefficients for Work-Leisure Concepts

Work-Leisure Concepts	Subjects	
	Coefficient	Probability
1. Myself	.04	.69
2. Freedom	.01	.92
3. Creative Behavior	-.02	.82
4. Time-Killing Activity	.70	.0001
5. Development of Talent	.09	.34
6. Physical Energy Input	-.14	.11
7. Service to Others	.10	.27
8. Status	.08	.40
9. Relaxation from Tension	.07	.41
10. Social Relationships	.26	.003
11. New Experiences	.06	.53
12. Competition	-.07	.46
13. Leadership	.19	.04

___ Significant at ($p \leq .05$) level.

Conclusions

Given that this study surveyed only wheelchair basketball participants, one must be careful not to generalize the findings to all wheelchair athletes and most certainly not to all physically disabled persons. The results obtained in this study indicate that this sample of wheelchair athletes favorably perceived both their work and their leisure as evidenced by the finding that 12 of the 13 work-leisure concept statements received positive ratings. These results were consistent with other studies that have utilized the WLAI to examine work-leisure meanings among university employees (Hunt, 1979), industrial workers (Hunt and Brooks, 1980), retirees (Hunt and Weiner, 1982) and unemployed adults (Hunt, 1985). It should be noted that the number of concepts found to be significantly similar in this study (three) was much lower than the number of statistically significant relationships found in those studies listed above which utilized the same instrument with different populations. However, all statistically significant relationships have been positive correlations, high score on work concept - high score on leisure concept; low score on work concept - low score on leisure concept. This seems to indicate a spillover effect, in that work attitudes and meanings may be so ingrained in American culture that they carry over to non-work activities as well.

Implications for Future Research

As is the case in most research projects, this investigation has probably raised as many questions as it has answered. Specifically, the following concerns could be addressed in future studies:

(1) Do wheelchair athletes in individual sports such as tennis or swimming conceptualize their work and leisure differently than those who participate in wheelchair basketball?

(2) Do physically disabled individuals who are not involved in competitive wheelchair sports feel differently about the meanings of work and leisure in their lives?

(3) Does the level of disability experienced by the wheelchair athlete affect his/her perceptions of work and leisure?

(4) Do individuals with different types of physical disabilities feel differently about the meanings of work and leisure in their lives?

In summary, social science research on the work-leisure relationships has produced few conclusive findings. This investigation is no exception to that rule. However, several re-conceptualizations of the work-leisure relationship are beginning to evolve. Such evolution is due to the dissatisfaction with the overall state of research in the work-leisure relationship and its limited ability to explain variance in leisure behavior (Zuzanek & Mannell, 1983).

The following suggestions made by researchers in this area of study are enlightening regarding problems encountered in this investigation. Mannell & Iso-Ahola (1984) have suggested that the difficulties in establishing clearer relationships between work and leisure stem from methodological and operational deficiencies. These deficiencies include unidimensionality in defining the work situation and highly insensitive measures of leisure. Improvement of measurement tools might increase the explanatory potential of research into the work-leisure relationship. Another problem area addressed by researchers is related to the multifaceted and multidirectional nature of the work-leisure relationship. Kando & Summers (1971) noted that the same individual can experience spillover and compensation relationships between work and leisure under different circumstances. Roadburg (1982) suggested the study of work-leisure relationships examine the interaction effects of specific work and leisure situations rather than more broadly defined work and leisure activities. Others believe that the choices of work and leisure, as well as their relationships, may reflect basic differences in the personality structure of the individual. They purport that work-leisure relationships stem from such variables as values, motives, and social attitudes which influence both occupational and leisure choices (Bishop & Ikeda, 1971). Kabanoff & O'Brien (1980) suggested that the work-leisure relationship be used as an independent variable, or an active personality characteristic. Such use can explain how activities and satisfaction with life are structured by individual differences in personal orientations to work and leisure rather than solely by the constraints of the work situation.

Irrespective of few conclusive findings thus far in this particular area of social science research, it is encouraging to note that the recent reconceptualizations of the work-leisure relationship may provide a sound basis for continuing study. This entire area of work-leisure meanings, and the factors which shape their relationship, appears to be one which is fertile for empirical investigation.

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Answering Questions About Therapeutic Recreation Part I: Formulating Research Questions

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Abstract

Recognizing that therapeutic recreation specialists may find the prospect of conducting systematic research an awesome task, this paper seeks to explain how research methods are related to theoretical assumptions. A subsequent paper identifies and describes specific research strategies that therapeutic recreation specialists may find useful when attempting to answer research questions. In the first part of this paper, we show how the choice of research methods is related to *underlying paradigmatic assumptions* espoused consciously or unconsciously by the investigator. Two categories of paradigms are discussed within this paper: normative paradigms and interpretive paradigms. Next, we will show how these two paradigms are related to the generation of theory. Finally, we show how these paradigms are related to the formulation of hypotheses and specific research questions in therapeutic recreation research. This paper is intended to encourage specialists to consider different paradigms when attempting to answer questions relevant to the practice of therapeutic recreation.

Though research in the field of therapeutic recreation has potential impact upon leisure service delivery to people with disabilities (Compton, 1984), research in this area has been shown to have a number of limitations. Perhaps the most debilitating limitation is the absence of a systematic research tradition in therapeutic recreation. The knowledge base of therapeutic recreation has been dominated by what Witt (1988) described as the "power of thought apart from testable data" (p.15). Witt added that therapeutic recreation research is slowly progressing from the *social philosophy stage of knowledge*, where knowledge is based on speculation, rationalization and conjecture, through the *social empiricism stage of knowledge*, where knowledge is based on descriptions of existing conditions, to finally the *social analysis stage of knowledge*, where knowledge is based on systematic efforts to understand relationships. A related limitation is the small number of actual research studies annually published (cf. Iso-Ahola, 1988). Of the studies that have been published, the majority have reported findings dealing with a few disability groups, with some groups receiving scant empirical attention (Iso-Ahola, 1988). A third limitation is that therapeutic recreation research has relied on a limited number of specific research methods. For example, Mannell (1983) reported that survey methods were the predominant method of data collection in research published in the *Therapeutic Recreation Journal* and the *Journal of Leisurability* between the years 1968-1982. Similar findings were reported by Schleien and Yermakoff (1983).

The above discussion may be summarized very simply: the body of knowledge upon which therapeutic recreation practice is based is limited due to the absence of a research tradition and the over-reliance upon survey methods.[1] To advance the

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knowledge base in which therapeutic recreation practice must be grounded, continued research efforts are needed. Many therapeutic recreation specialists, however, find the prospect of conducting research overwhelming given their inexperience in conducting research and/or the numerous options of research methods available in social sciences. If there is anxiety among therapeutic recreation professionals in these matters, it may be a result of a lack of knowledge of research principles. Anxiety may also stem from a lack of exposure to the linkage between the act of creating research questions and the choice of appropriate research methods. Indeed, the decision to use one research method over another may be a function of the investigator's *familiarity* with the method rather than his or her *understanding* of whether the method is appropriate in answering a specific question. Finally, anxiety among therapeutic recreation professionals may also be related to their unfamiliarity with how theoretical perspectives guide research.

This paper provides the therapeutic recreation practitioner a basic understanding of how research methods are related to theoretical assumptions. In the first part of the paper, we will show how the choice of research methods is related to *underlying paradigmatic assumptions* espoused consciously or unconsciously by the investigator. In the second part of the paper, we demonstrate how these assumptions are related to the generation of theory. In the last section of the paper, we discuss how paradigmatic assumptions are related to the formulation of hypotheses and specific research questions in therapeutic recreation research. A subsequent paper will identify and describe specific research strategies that therapeutic recreation professionals can use when attempting to answer research questions.

As a point of departure, we agree with Compton (1989) who advocated that researchers in therapeutic recreation should be familiar with a variety of research methods. An *eclectic* research focus provides the professional a myriad of research tools to answer different research questions relevant to therapeutic recreation. An eclectic approach also echoes Kelly's (1980) argument that leisure researchers, such as those attempting to answer questions relevant to therapeutic recreation, cannot begin to understand the complexities of leisure without embracing a range of research strategies:

> Leisure is such a multi-dimensional phenomenon that each research approach has the potential of furthering our understanding of some dimension. . . . There is no single method that can begin to encompass, much less exhaust, a complex phenomenon as leisure (p. 312).

The Grounding of Research in Theoretical Paradigms

Research questions tend to lend themselves to different methods of study (Mannell, 1983; Zelditch, 1969). Furthermore, the choice of research methods dictates how information is defined, collected, analyzed, and reported (Denzin 1978). In reality, however, the use of a particular research method is often related to a person's academic training, an indication of acceptable practice, and/or a person's philosophical assumptions about the nature of the empirical world (Rist, 1977). In this section we explore these *hidden* factors as a means of elucidating how paradigmatic assumptions underlie most social research.

> Theoretical paradigms were described by Ritzer (1975) in the following terms: A paradigm is a fundamental image of the subject matter within a science. It serves to define what should be studied, what questions should be asked, how they should be asked, and what rules should be followed in interpreting the answers obtained. The paradigm is the broadest unit of consensus within a science and serves to differentiate one scientific community (or sub-community) from another (p. 157).

Weimer (1979) used a similar term, *metatheory*, to describe a conceptual scheme that enables researchers to interpret any conceivable instance of a phenomena falling within its domain. Both the notions of theoretical paradigm and metatheory suggest that observations or occurrences within the world are ordered and interpreted in terms of paradigmatic or domain assumptions. As noted below, this has profound impact on how researchers view a particular phenomenon, and how research questions are subsequently formulated.

There are many specific theoretical paradigms within the social sciences. In sociology, examples of specific paradigms include structural-functional

theory, conflict theory, exchange theory, and symbolic interactionism. Examples of paradigms in psychology and social psychology include gestalt theory, field theory, reinforcement theory, and psychoanalytic theory. Two broad categories of paradigms appear to incorporate individual paradigms. These two categories, as described by Wilson (1970), include *normative paradigms* and *interpretive paradigms*.[2] Normative paradigms explain behavior in terms of rules, and the form of the explanation is largely deductive. The *deductive* method of reasoning, attributed to Aristotle and the Greeks, is one in which general premises are related to specific instances (Best, 1977). Deci's (1980) organismic theory of motivation serves as a useful example. A basic assumption of the theory is that people's perceptions and cognitive evaluations of the environment develop from their experiences in satisfying the basic needs of self-determination and competence. This premise may be readily applied to an analysis of people with disabilities. Specifically, the therapeutic recreation specialist may hypothesize that when people with disabilities are given choices during recreation participation they will express a higher level of satisfaction than if they are not afforded such choices.

Interpretive paradigms include theoretical systems which conceive behavior as a formative and emergent process, and explanations are largely inductive rather than deductive. *Inductive* reasoning begins with specific observations and then builds toward general patterns, thus, attempting to make sense of a situation without imposing preexisting expectations (Patton, 1980). For example, therapeutic recreation specialists working in chemical dependence observe that people suffering from alcoholism frequently express feelings of deviancy during counseling sessions. This observation may lead to the general hypothesis that people with alcoholism perceive themselves to be different from others and act toward the world based on these perceptions.

The Grounding of Research Within Normative Paradigms

What does it mean that behavior is explained in terms of rules? Very simply, it means that behavior is conceived in terms of a causal chain, whereby variation in one factor (an independent variable) produces a necessary change in another factor (a dependent variable). The fundamental premise to this position is that there are various social, psychological, and physiological forces and drives which have an objective reality apart from individual meaning and motivation. Although people may be regarded as conscious and capable of decisive action, human thought and action are ultimately explained in terms of these forces and drives.

Sociological paradigms that are characteristic of the normative framework explain social life in terms of *social facts*. That is, the individual and his/her social behavior are "largely determined by social structure and institutions" (Ritzer, 1975, p. 159). There is virtually an endless number of social facts that can be seen to have an impact on human behavior, including occupation, education, income, laws, customs and so on. Psychological and social psychological paradigms - gestalt theory, field theory, reinforcement theory, and psychoanalytic theory - explain behavior in terms of different conceptions of humankind. Together, however, the perspectives assume that the individual is composed of "a set of built-in needs, drives, and psychic or physiological demands which call out fixed responses" (Lindesmith, Strauss, & Denzin, 1975, p. 8).

With normative paradigms, explanations of behavior follow the deductive logic of the natural sciences (Wilson, 1970). A deductive argument in the natural sciences includes a description of objects or events that has a stable meaning across a range of situations. In research, this is facilitated by the creation of concepts and operational definitions that are unambiguous and context-free in terms of their meaning. Concepts, in their most elemental form, are intellectual tools used for guiding research. Concepts are abstract, however, and are ordinarily operationalized using fixed or established indices. Once a concept is given a stable meaning, it may be easily expressed in quantitative terms, thus, providing an empirical standard so that phenomena may be compared across a variety of situations (Rist, 1977; Scott & Godbey, 1990). For example, a concept such as *social class* becomes simplified and readily communicated if operationalized using indicators such as income and level of education. These operations are straightforward and unambiguous, and provide a reliable index for measuring the concept.

The Grounding of Research Within Interpretive Paradigms

Interpretive paradigms are united under the

assumption that behavior is a formative and emergent process in its own right. More simply, the individual is conceived as an active agent within his or her particular life-space. Unlike the normative paradigm, then, behavior is not treated as an expression of structural forces and acquired dispositions. Instead, the individual is seen as actively involved in the organization of daily routines (Blumer, 1966, 1969).

Advocates of the interpretive paradigm seek to explain behavior by discovering the social meanings underlying human activity. It is believed that the meaning of social phenomena (ways of doing things, material objects, etc.) are constructed out of social interaction. From an interpretive paradigm, then, social phenomena have no intrinsic meaning. That is, reality is not constructed in the same manner for all people (Bullock, 1983). For example, the meaning of the term leisure may have qualitatively different meanings for different people. For some people, the term may connote the freedom to pursue activity that is pleasurable. For others, the term may suggest an absence of productive work. In any case, a research approach grounded within the interpretive paradigm might seek to discover the meaning of the term across different groups and explain how people within these groups act on the basis of their shared definition of the term.

Methodologically, research grounded within interpretive paradigms use an *inductive* logic rather than a *deductive* logic. Methods chosen are ones that are sensitive to individual experiences. Examples of methods appropriate for this type of research include participant observation, in-depth (open-ended) interviewing, life history interviewing, content analysis of personal and official documents, and experience sampling method. These methods have been described as *naturalistic* because they seek to depict social life as it appears to people under investigation. Frequently, neither hypotheses nor operational definitions are used when using naturalistic methods. Instead, concepts and hypotheses are actually generated from data (Glaser & Strauss, 1967).

Theory and Generating Research Questions

A theoretical paradigm, although bound by key assumptions, represents only a general orientation to the study of behavior. The paradigm provides clues as to the types of variables or questions of interest without providing a systematic explanation of any given phenomenon (Deutsch & Krauss, 1965). To systematically explain behavior, theoretical paradigms are comprised of a number of *middle range* theories (Merton, 1957). A theory of the middle range is consistent with traditional definitions of theories. That is, it is a systematic explanation of some phenomenon which includes an integrated body of definitions and propositions. Theories of this type typically seek to explain a limited amount of human behavior. Examples of middle range theories in leisure research include Iso-Ahola's (1986) theory of substitutability of leisure activity, Csikszentmihalyi's theory of enjoyment (1975), and Parker's theory of work-leisure relationships (1971). Although theories generated within both normative and interpretive paradigms seek to explain phenomena in the social world, the process in which this occurs differs markedly depending on one's paradigmatic orientation.

Theories grounded within a normative paradigm specify the need to establish causal relationships among selected variables *prior* to implementing investigations. This is done by generating hypotheses that lend themselves to systematic testing. The research act is then a means of *verifying* the usefulness of the theory. Hence, normative theories not only seek to explain social life, but they also ideally serve as a *guide*, in the form of hypotheses, for systematic research.

Theories grounded in interpretive paradigms, on the other hand, are *discovered* after pursuing systematic research. Hypotheses and explanations of behavior are proposed (grounded) from actual incidents in the empirical world (Glaser & Strauss, 1967) once intimate experience and in-depth knowledge of social world activity is developed. Therefore, something other than hypotheses and operational definitions must be used in guiding research. To provide the opportunity for discovery, general research questions are used that are relatively open-ended in conjunction with sensitizing concepts (Blumer, 1954). Sensitizing concepts provide clues and suggestions upon which to make observations. Concepts of this sort are not treated in a precise, definitive manner. Instead, they are used merely as a point of reference in the process of discovering patterns of behavior.

Normative Paradigms

Ideally, a research approach grounded within a normative paradigm would be one where hypotheses are derived and tested within the framework of a middle range theory. In many cases, however, hypotheses or specific research questions are derived which are divorced from theory. Still, there is an underlying belief that the empirical world is lawful and is subject to systematic investigation using concepts and definitions that have an unambiguous and objective meaning.

What does this say about the study of leisure? From a normative paradigm, leisure is defined (treated) as something that can be observed or inferred as it is believed to exist independently of subjective experiences. The implication is that leisure may be reduced to its most elemental components for purposes of systematic inquiry. As noted above, this is accomplished by defining and operationalizing terms using straightforward and unambiguous procedures.

Studies on leisure motivation (e.g., Beard & Ragheb, 1983; Crandall, 1980; Iso-Ahola & Allen, 1982) serve as a useful case in point. A research question might be posed as follows: "Are certain leisure motives associated with certain leisure behaviors?" Two variables or components are inferred from this question. First, there is the issue of what constitutes a leisure motive. Leisure motives must be defined in such a way that it provides a clear definition of the concept as well as providing a method for observation. This is typically done by generating a number of questions that collectively form a leisure motives scale. For instance, a sample item used to measure leisure motivation is "I like to see the results of my efforts" (e.g., Crandall, 1980). The assumption here is that all people who see or hear this statement will interpret it in a similar manner. To the extent that the item is shown to be correlated with items of a similar nature, the assumption seems plausible. Second, leisure behaviors must be operationalized in some systematic fashion. This may be readily done by defining leisure as activity, such as dancing, camping, cycling, and so on. This definition is not only unambiguous, it provides a ready means of classifying people into categories of leisure behavior. After a sample of representatives of each category of leisure behavior are tested in regard to their leisure motives, a simple statistical procedure (e.g., analysis of variance) may be performed. From this, it may be determined whether certain motives are associated with certain leisure behaviors.

This approach may be readily extended to studying the efficacy of therapeutic recreation interventions. Therapeutic recreation professionals are interested in a number of questions. What is the most efficacious leadership style in a specified leisure education program with a specific group of people with disabilities? Is one type of leisure education program more effective in increasing leisure satisfaction than another? Does an appropriate leisure lifestyle contribute to a high quality of life? Each of these questions can be answered using a similar strategy as described above. In short, variables of interest are operationalized in such a way as to facilitate systematic testing.

Interpretive Paradigm

Research grounded within an interpretive paradigm does not seek to explain social life in terms of mere variables. As noted already, interpretive paradigms treat humans as active agents in the way they go about their daily routines. Hence, behavior is not a mere expression of social and psychological forces; rather, it is conceived as something that people accomplish. The goal, then, of interpretive research is to *discover how people go about organizing their behavior*. This entails discovering how people interpret and define both their environment and their actions. To this end, a research design is naturalistic and holistic: researchers ideally study people within the context of their day-to day affairs, and analysis incorporates a range of factors and conditions.

The implications for leisure research may be stated as follows: the proper study of leisure is within the context of actual involvement. On the one hand, this means that leisure may be studied within the stream of people's on-going experiences. The experience sampling method, for example, provides data which assess people's moods, emotional and physical states, and their rationale for participation in a given activity.[3] On the other hand, studying leisure in terms of actual involvement means studying leisure as a formative process. In this regard, research is centered on how people create patterns (styles) of activity in light of opportunities, role definitions,

perceived constraints, various personality needs, and so on.

A fundamental question, then, to be answered in research grounded within the interpretive paradigm is: how do the people under study view their world or certain aspects of it? Specific research questions relevant to therapeutic recreation can readily be generated: What is the experience (meaning) of leisure among people with disabilities? What is the experience (meaning) of leisure in institutions? What strategies do people in institutions employ to experience leisure? What is the perception of therapeutic recreation programs among people with disabilities? Can therapeutic recreation interventions change how people view their world? An answer to these questions entails an integrated and holistic explanation that is gleaned from the study of *lived experiences*, as expressed in verbal accounts and observed behavior.

Therapeutic Recreation as an Eclectic Profession

In this paper, we have sought to demonstrate how normative and interpretive paradigms are related to the choice of research methods. In general, research conducted within the framework of a normative paradigm seeks to demonstrate the relationship among variables. This approach to research stems from an assumption that social life is law-like. That is, behavior is explained in terms of a causal chain: change in one factor (an independent variable) is thought to lead to change in another factor (a dependent variable). Consistent with the logic of deductive reasoning, hypothesis and operational definition are constructed *a priori* as a means of guiding the research process. On the other hand, research grounded within an interpretive paradigm seeks to discover how people actively go about organizing their daily routines. Research, then, is more of an inductive affair whereby hypotheses and concepts are discovered from having participated in the lives of the people under investigation. Research methods are naturalistic in the sense that people are studied within the context of their day-to-day affairs, and analysis incorporates a variety of factors and conditions. This research approach stems from the belief that the individual is an active agent within his or her life space.

Historically, people conducting research related to therapeutic recreation have been trained using only one paradigm. While a particular paradigm is useful in many situations, it is only one perspective in approaching the study of leisure in therapeutic settings. Educators exposing their students to only one paradigm are encouraged to explain and demonstrate the effectiveness of other paradigms and associated methods. Such an approach to the study of social life results in questions dictating the types of methods appropriate for study. The practice of choosing research methods prior to establishing a research question, rather than the reverse, can be hazardous to professionals attempting to conduct useful research.

Therapeutic recreation is a profession serving a wide range of individuals. People receiving therapeutic recreation services may vary considerably in skills, limitations, age, interests and experiences. For instance, therapeutic recreation specialists can be found providing intense therapy with young adolescents recovering from traumatic injuries, leisure education with older adults requesting psychiatric services, or recreation participation for young children experiencing serious terminal illnesses. To respond to the diversity of people served and the myriad of environments where services are provided, therapeutic recreation specialists are required to employ a variety of intervention strategies generated from different theoretical perspectives. Therefore, therapeutic recreation is viewed as an eclectic profession (Austin, 1982). To meet the needs of their consumers, therapeutic recreation specialists must be open to different perspectives and recognize that some intervention strategies may be more effective with some individuals than others. Practitioners often blend interventions emerging from humanistic, behavioristic and psychoanalytic perspectives.

The acceptance of an eclectic position in reference to the practice of therapeutic recreation is not only valuable but appears necessary for survival of the profession. The intention of the authors is to encourage professionals to continue using this eclectic perspective when attempting to empirically answer questions related to therapeutic recreation. The diversity associated with therapeutic recreation creates a multitude of questions to be answered. Some questions related to therapeutic recreation may be best answered through a normative paradigm while

the interpretive paradigm may be superior in answering other questions. In many situations it may be extremely valuable to incorporate both paradigms to allow professionals to gain in depth understanding into some issues.

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Footnotes

1. We do not criticize the use of survey methods in therapeutic recreation research; we do question, however, the use of survey methods at the expense of other methods.

2. Many writers associate normative paradigms with quantitative research and interpretive paradigms with qualitative research. Although there is a tendency for researchers working within a normative paradigm to use methods that generate quantitative data and researchers working within an interpretive paradigm to use methods that generate qualitative data, the methods themselves are not in themselves inherently quantitative or qualitative.

3. In studies utilizing the experience sampling technique, subjects carry an electronic pager and a questionnaire booklet for a specified period of time. At random intervals, subjects are beeped thus serving as a stimulus for them to complete self-report forms.

Answering Questions About Therapeutic Recreation Part II: Choosing Research Methods

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Abstract

To systematically answer questions relevant to the practice of therapeutic recreation, specialists increasingly recognize the necessity of pursuing research. If therapeutic recreation professionals are to build a specialized body of knowledge, they must become familiar with a variety of research methods. In this paper, five research methods are presented: experimental methods, single-subject methods, survey methods, participant observation, and in-depth interviewing. The first three methods are generally associated with normative paradigms, while the latter two are generally associated with interpretive paradigms. The five methods are discussed in terms of sampling, data collection, data analysis, strengths and weaknesses, and applications to therapeutic recreation. It is hoped that specialists will consider a variety of research methods when attempting to answer questions relevant to the practice of therapeutic recreation.

The purpose of the paper, *Answering Questions About Therapeutic Recreation Part I: Formulating Research Questions*, was to provide therapeutic recreation professionals an understanding of the linkage between theoretical paradigms and the generation of hypotheses and research questions. Two categories of paradigms were discussed: normative and interpretive. Normative paradigms explain behavior in terms of a causal chain, whereby change in one factor (an independent variable) is examined in terms of its influence on another factor (a dependent variable). Following the logic of deductive reasoning, hypotheses and research questions are constructed to allow for systematic testing of the relationship among variables. This is facilitated by operational definitions that are unambiguous and have a stable meaning across different situations. Interpretive paradigms, on the other hand, explain behavior as a formative process: the individual is treated as an active agent within his or her life space. Research grounded in the interpretive paradigm seeks to discover how people actively go about organizing their daily routines. Research, then, is an inductive process where hypothesis and explanations are discovered from having participated in the lives of people under investigation.

The focus of the previous paper serves as a foundation for this paper--the examination of specific research methods appropriate for therapeutic recreation. In this paper, five types of research methods are presented: (a) experimental research, (b) single-subject research, (c) survey methods, (d) participant observation, and (e) in-depth interviewing. The first three methods are generally associated with normative paradigms, while the latter are typical of interpretive paradigms.[1] The choice of these

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methods, on the one hand, serves to illustrate how normative and interpretive research strategies are used. On the other hand, the five research methods were chosen because they appear to be the most frequently used and suited to answer questions about the implications of therapeutic recreation services on the lives of persons with disabilities. Each research method will be described relative to sampling, data collection[2], and data analysis. Moreover, the strengths and weaknesses associated with each method will be briefly discussed. Finally, specific examples of the application of each research method in therapeutic recreation research will be presented.

Given the space limitation, it is impossible to describe all factors relevant to each of the five research methods. What we hope to do is provide the therapeutic recreation practitioner a simple understanding of how each of the methods may be used. The reader is advised to examine the various references to further his or her knowledge of how the five methods may be applied to his or her particular situation.

Research Methods Appropriate for Normative Research

Three methods associated with normative research are described: (a) experimental designs, (b) single-subject designs, and (c) survey designs. These three methods have been selected because they offer ways to clearly understand leisure behavior of persons with disabilities and allow therapeutic recreation research to focus on relationships among variables.

Experimental Methods

Studies that use experimental research methods seek to answer questions concerning causal relationships among factors (variables) through a process of manipulation and control. In the most simple case, one factor is deliberately manipulated while all other factors are held constant (controlled), and the effects of the manipulation upon another factor are observed. In experimental terms, the manipulated factor is termed the independent variable and the observed factor is the dependent variable. The logic of experimental research is straightforward: if distinct groups of subjects are treated exactly the same except for the independent variable, any difference observed among the groups in terms of some dependent variable is due in all likelihood to the independent variable (Johnson & Solso, 1978).

Before describing the elements of experimental design, it should be noted that therapeutic recreation research is more apt to use what is known as quasi-experimental research rather than true experimental research. In true experimental research, control of extraneous variables is accomplished at the expense of realism. Indeed, subjects in true experimental research are often conscious that they are participants within an experiment. In quasi-experimental research, control of extraneous variables is often sacrificed in favor of realism: subjects in quasi-experimental research are frequently not aware that they are participants within an experiment. Although not always possible, quasi-experimental designs should approximate true experimental designs as a means of insuring validity of results.

Sampling. In experimental research, subjects in the experimental group should possess similar characteristics (age, intelligence, personality type, level of education, type of disability, and so on) as subjects in the control group. This may be accomplished by randomly assigning subjects to experimental and control groups respectively or by matching. If subjects in experimental and control conditions are not different, the external validity of experimental findings are strengthened. If these conditions are not met, the generalizability of experimental results to other groups, situations, or settings may be questioned (Cook & Campbell, 1979).

Data collection. Data collection in experimental research revolves around themanipulation of one or more independent variables and determining how this influences a dependent variable. An independent variable is manipulated in such a way that subjects within an experimental group receive some different treatment than subjects within a control group. For example, in a therapeutic recreation setting, clients may be divided into two programs which differ in terms of the types of motor skills used. The dependent variable is measured using some specified test or instrument. In some studies, it may be of interest to determine how clients change over time in regard to some predefined measurement. In these cases, a test or instrument is administered at some point preceding (pre-test) and at some point following (post-test) experimental manipulation. Differences between pre- and post-test scores constitute the dependent variable for all experimental and control group subjects.

During experimental manipulation, it is important that experimental and control group subjects receive the same treatment except for the specified experimental manipulation. The internal validity of the study is threatened if observed differences between experimental and control group subjects can be explained away by some measurement artifact. For example, experimental and control group subjects may participate in the experiment under the direction of different investigators. Observed differences may be a function of investigator error rather than experimental manipulation (Cook & Campbell, 1979).

In choosing an instrument to measure the dependent variable, the reliability of the test must be determined. Reliability of an instrument focuses on the consistency and accuracy of the test. The pivotal question surrounding the reliability of a measurement may be stated as follows: would similar results be obtained if this experiment were performed again with the same groups?

Data Analysis. Measures of the dependent variable are first reduced by calculating measures of central tendency (e.g., means) and dispersion (e.g., standard deviations) for pre- and post-test scores for each group separately. Statistical analysis is then used to determine whether differences between groups are greater than chance occurrence. Results of this analysis are generally presented in tabular form, particularly in the form of t-test tables and analysis of variance tables.

Strengths and weaknesses of experimental methods. True experimental research is regarded by many writers as invaluable in explaining hypothesized relationships between two variables (Isaac and Michael, 1981; Mannell, 1980). The reason for this is that experimental methods allow for the isolation of an independent variable to determine its effect on some dependent variable. Hence, a key advantage of true experimental research is the experimental control over extraneous variables. The major disadvantage of this method is that to gain this degree of control, the experiment is usually conducted in a laboratory where subjects behave under highly artificial conditions. Indeed, true experimental research has been criticized because subjects tend to be responsive to the demand characteristics of the experiment (Orne, 1962). Second, it is difficult to strictly follow conventions of probability sampling in therapeutic recreation settings because of problems in identifying the entire population. While researchers may wish to conduct an experiment with a particular group of people with a disability, it may be infeasible because people who have the particular disability may not be institutionalized or known. Similarly, the design cited as affording the most control--Randomized Solomon Four Group design--requires four separate groups of subjects (Campbell & Stanley, 1963). Locating enough subjects to fulfill the requirements of this design is often prohibitive in therapeutic recreation settings. Another difficulty arises in ethical concerns of withholding treatment, or using a placebo treatment, with control groups. However, this difficulty may be overcome by allowing the control groups to receive the treatment following the final post-test.

The net result of these difficulties is that most experimental research in therapeutic recreation is more appropriately termed quasi-experimental research (Mannell, 1983). As noted, in quasi-experimental research, researchers approximate conditions of the experiment (cf. Isaac & Michael, 1981). These approximations lessen the degree of control over threats to both internal and external validity.

Example of experimental research to therapeutic recreation. Shary and Iso-Ahola (1989) were interested in examining the effects of a control-relevant intervention strategy (independent variable) on nursing home residents' perceived competence and self-esteem (dependent variables). Specifically, it was of interest to determine whether increased opportunities to exercise personal choice and responsibility led to an increased feeling of competence and self-esteem. The independent variable was manipulated by varying the amount of personal choice and responsibility nursing home residents were allowed to exercise. The dependent variable was measured using two scales. Perceived competence was measured by a 10-item scale developed by the authors, and self-esteem was measured by a 10-item Self-Esteem Scale developed by Rosenburg (1965). Subjects were administered pre- and post-tests before and following the intervention strategy. After analyzing the data with one-way analysis of covariance, Shary and Iso-Ahola (1989) reported that nursing home residents allowed to exercise personal control and responsibility had a significantly increased sense of competence and self-esteem

compared to nursing home residents not allowed to exercise personal control and responsibility.

Single-Subject Methods

Single-subject methods offer an alternative experimental approach to answering questions of causal relationships. The essential feature of a single-subject design is that all conditions are applied to the same subject, and the results of the change in behavior are analyzed with respect to that individual (Repp, 1981). Typically, single-subject designs examine a few cases extensively, via repeated measurement, to verify functional relationships between an individual's behavior and environmental changes (Dattilo, 1986). This procedure stresses inferences pertaining to and findings applicable to the individual (Dattilo, 1989). The application of this method involves designing investigations which allow therapeutic recreation specialists to determine an individual's performance and infer with confidence that a functional relationship between planned interventions and behavior change exist (Dattilo, 1986).

Sampling. Sampling in single-subject designs is usually accomplished through judgmental sampling (Babbie, 1989) which is a form of purposive sampling.' Subjects are chosen based on criteria that are judged relevant by the researcher. Effective use of judgmental sampling requires an adequate knowledge of the population under investigation. Since utilization of single-subject designs permit development of applied research, therapeutic recreation practitioners are able to work directly with subjects as a means of generating results that have an impact on their day-to-day lives (Kazdin, 1982).

Data collection. Single-subject research seeks to address changes in a dependent variable following introduction of an independent variable on an individual. While single-subject experiments may involve more than a single person, results are reported in terms of each individual rather than as an aggregate. To control for internal validity, single-subject designs require each individual to act as his or her own control by permitting the systematic application of all conditions to each subject (Dattilo, 1987; Repp 1981). In addition, internal validity is enhanced through repeated measurement of the dependent variable. This permits extensive examination of changes in behaviors over time, thus mitigating the possibility of attributing change to historical accidents. External validity is enhanced in single-subject research through various forms of replication (McReynolds & Thompson, 1986). Since overt behavior is the most common form of data in single subject research, reliability is strengthened by assessing the correspondence of data collected by separate observers.

Data analysis. In single-subject research, visual inspection of data are emphasized (Dattilo, 1989). According to Dattilo, visual inspection involves creating a graphic representation of the observations of each subject over the course of the experiment and visually inspecting this graph to identify magnitudes and rates of change. The creation of a graphic representation results in data display. Once this display has been created, data are reduced for each individual by identifying trends in data.

Strengths and weaknesses of single-subject research. Dattilo (1989) cited a number of advantages of single-subject research. One advantage is that this approach requires fewer subjects than true or quasi-experimental research, since subjects act as their own control. This contributes to a clinically feasible procedure. Because subjects act as their own control, treatment (independent variable) is applied to all subjects in the study. Thus, ethical concerns of withholding treatment can be addressed. Another advantage is that results are reported in terms of individuals as opposed to averages, allowing persons wishing to use the treatment in a therapeutic environment to examine individual responses to treatment. A major disadvantage of single-subject designs is that it has limited external validity due to the small number of subjects. Another disadvantage is that units of analysis in single-subject designs are typically observable and measurable behaviors (Dattilo, 1989). As a result, concepts not readily operationalized in terms of behaviors may not lend themselves to this method.

Example of single-subject research to therapeutic recreation. Schleien, Cameron, Rynders and Slick (1988) examined the effects of a multi-faceted training program on the acquisition and generalization of (a) three specific recreation activity skills, (b) social interaction skills, and (c) play behaviors (i.e., cooperative and appropriate). The investigators employed a multiple-baseline design across behaviors (different activities) replicated across two children with severe multiple disabilities. Schleien and colleagues observed that both children gained

sufficient skills to participate independently in two of the three recreation activities, and demonstrated improvements in social interactions and the ability to play.

Survey Methods

According to Kerlinger (1973), survey research examines populations, both large and small, as a means of answering questions about the "relative incidence, distribution, and interrelations of sociological and psychological variables" (p. 410). Examples of relevant sociological variables include sex, education, race, age, and size of family, while examples of psychological variables include attitudes, motives, and opinions. Survey research is particularly appropriate when variables do not lend themselves to experimental treatment and controlled manipulation. Historically, survey research has been the predominant method in leisure (Riddick, DeSchriver, & Weissinger, 1984) and therapeutic recreation research (Iso-Ahola, 1988; Mannell, 1983). While this trend has been criticized (Mannell, 1983), the need for rigorous survey research exists as a means answering various research questions.

Sampling. The ideal sampling method in survey research is probability sampling (Babbie, 1989). As in experimental research, probability sampling is particularly useful for establishing external validity since respondents are assumed to be representative of the population from which it was drawn.

Data Collection. Data collection involves two primary steps. First, a suitable survey instrument must be located or developed. The primary criterion for using or not using an instrument is the extent to which it adequately addresses the research question (Babbie, 1989). This means that concepts must be operationalized in the form of questions or statements that allow for consistent and straightforward measurement. Equally important, however, is that operational procedures must accurately define the concepts under investigation. For example, using a previously developed scale that includes multiple items is often prudent because it allows for identification of reliability and internal validity prior to implementation. If a suitable instrument cannot be located, the researcher may face the task of creating a new one. Pilot-testing the new instrument allows for the identification of biased, ambiguous or confusing questions (Isaac & Michael, 1981). In this way, the reliability and internal validity of the instrument is maximized.

In conjunction with the development of an instrument, implementation strategies must be considered. Survey instruments are typically implemented in one of three ways: (a) through the mail; (b) in the context of face-to-face interviews; and (c) in the form of a telephone interviews. Depending on the type of implementation strategy devised, researchers must consider factors such as the number of mailings, strategies for randomly selecting subjects (e.g., random digit dialing, selection of individuals from households), training of interviewers, and handling of non-responses.

Data Analysis. As with experimental group design, statistical procedures are typically used in the analysis of survey data. Indeed, the hallmark of survey research is the testing of statistical relationships among several variables. In this way, results of survey analysis are reported in the form of interrelationships, main effects, and interactions (Rosenburg, 1968).

Strengths and weaknesses of surveys. Surveys offer some advantages in studying complex concepts since it is possible to operationalize a single concept through a number of procedures. Another advantage is that surveys can collect data from large numbers of subjects efficiently. If researchers are studying a large population, a survey is the most efficient method that can be utilized to collect data from a sample large enough to be considered representative. A third advantage is that surveys frequently offer the possibility of testing rival hypotheses and exploring other (secondary) relationships. This is facilitated by incorporating a multitude of other survey items within the data set. The primary disadvantage of surveys is that they are unable to determine cause and effect among variables. The best a survey can do is identify relationships, but even these may be misleading because of the presence of extraneous or uncontrolled variables (Rosenburg, 1968). A second disadvantage of surveys is they are a reactive method (Isaac & Michael, 1981; Kerlinger, 1973). The instrument may tip-off the respondent as to socially *appropriate* responses. Similarly, surveys often encourage people to respond to questions pertaining to situations that are completely hypothetical, if not completely divorced, from their day-to-day experiences (Scott & Godbey, 1990). In these ways, respondents can control or manipulate their responses in such a way that the validity of the results are

threatened. A final disadvantage is that surveys are not structured to allow for detailed answers. As noted by Kerlinger (1973), "the scope of the information sought is usually emphasized at the expense of depth" (p. 422).

Example of survey research to therapeutic recreation. Cunningham and Bartuska (1989) utilized the survey method in order to determine whether there was a relationship between stress and leisure satisfaction among therapeutic recreation specialists. Level of stress was operationalized using the Personal Strain Questionnaire (Osipow & Spokane, 1987). Leisure satisfaction was measured using the Leisure Satisfaction Scale (Beard & Ragheb, 1983). The researchers collected this information, along with pertinent demographic information, from 159 therapeutic recreation specialists. Correlation coefficients between the two scales were calculated yielding high negative correlation coefficients. Cunningham and Bartuska concluded that respondents with high levels of stress displayed low levels of leisure satisfaction.

Research Methods Appropriate for Interpretive Research

Topics appropriate for interpretive study can be in any area of substantive interest. However, topics that appear to be most appropriate to interpretive research are those defying quantification, best understood in a natural setting, and seeking to study social processes over time. Ideally, interpretive studies combine "in-depth understanding of the particular setting studied and general theoretical insights that transcend that particular type of setting" (Taylor and Bogdan, 1984, p. 17). Understanding occurs by becoming sensitive to the point of view of the people (informants) under investigation. Understanding also provides insight into how informants organize their knowledge (Spradley, 1979).

At the outset of the research project, research questions tend to be broad and general. As research progresses, however, a more focused approach ensues. The logic here is that researchers begin to know what questions to ask and how to ask them only after acquiring experience in the field. In light of this approach, sampling, data collection, and data analysis are highly flexible allowing researchers to adapt them to a particular setting. Two predominant interpretive research methods include participant observation and in-depth (open-ended) interviewing. These methods are, actually, better understood as forms of data collection, rather than distinct research methods. Indeed, matters of sampling and data analysis are identical in participant observation and in-depth interviewing. For this reason, the discussion of sampling and data analysis in this section is generic to interpretive research in general. However, participant observation and in-depth interviewing are discussed as distinct forms of data collection, and examples of how these methods have been used in therapeutic recreation research are provided.

Sampling

Generally speaking, data collection and data analysis occur simultaneously in interpretive research. Once themes and relevant categories of behavior are identified, specific incidents, activities, and individuals are sampled because they are believed to be relevant to emerging themes and theory. Hence, sampling in interpretive research ideally occurs through a process of theoretical sampling. Theoretical sampling is the purposeful sampling of cases or informants based on their presumed relevance for developing theory (Glaser & Strauss, 1967). In other words, sampling within interpretive research is directed by emerging theory.

Related to this approach is the concept of *negative cases*. According to Denzin (1978) *negative cases* are cases which appear to contradict emerging theory and are sought to test and modify theory. Sampling continues until saturation is reached - when traditional sampling fails to yield additional insights (Strauss, 1987).

Data Collection

Methods of data collection are sought which reflect how informants organize and view their world. To the extent that data collection procedures capture informants' perspectives, they enhance the internal validity of the study.

Participant Observation. Taylor and Bogtian (1984) defined participant observation as "research that involves social interaction between the researcher and informants in the milieu of the latter, during which data are systematically and unobtrusively collected" (p. 15). Utilization of participant

observation by therapeutic recreation professionals would require them to systematically adopt perspectives of people studied. In participant observation, then, investigators enter the world of the subject with the guiding question, "What is going on here?" (Bullock, 1983). As a means of answering this question, behavior and the contexts in which the behavior occurred are noted. These observations are recorded in field notes and become the data for analysis. The field notes ideally capture as accurate a description of the informants' world as possible. Field notes should also include the researcher's reflections. These reflective field notes are used to identify emerging themes of informants' worlds (Strauss, 1987).

Example of observational strategies to therapeutic recreation. Hunter (1987) sought to determine the types of changes that occurred among ten male youths, identified as adjudicated juveniles, as a result of participation in an outdoor rehabilitation program. Hunter collected data using the participant observation method supplemented with some unstructured interviews. Data were analyzed using a constant comparative strategy, whereby data were systematically recorded, coded and analyzed. Participant observation revealed that the rehabilitative program led to participants' experiencing success at tasks which were previously considered impossible by them, and participants' increased willingness to do more work than was required. Results of the study led to the generation of grounded theory--a set of integrated propositions gleaned from data that was systematically collected and analyzed.

In-depth interviewing. In general, interviewing may range from being completely closed and structured, to being completely open and unstructured (Burgess, 1984). In interpretive research, interviews lean toward the latter. Moreover, such interviews tend to resemble conversations in which neither the researcher nor the informant control the interchange (Burgess, 1984; Taylor & Bogdan, 1984; Schatzman & Strauss, 1973). Interviews are in-depth and are flexible enough to provide latitude in pursuing areas of informants' perceptions and knowledge which are identified in the course of the interview. Furthermore, questions tend to be non-directive, allowing informants to provide answers using their own words.

The interviewing process begins with a general area of interest and becomes increasingly focused with the emergence of themes of knowledge (Bullock, 1983). This means that even though the interview is conversational in nature, researchers enter the interview with a list of issues to be covered. Because in-depth interviews are open-ended, they are frequently tape-recorded and transcribed verbatim. As with participant observation, the recorded interviews are the data upon which analysis occurs.

Example of in-depth interviewing to therapeutic recreation. West (1986) was interested in exploring linkages between social service agencies that served persons with disabilities and agencies managing outdoor recreation resources. To accomplish his goal, West conducted in-depth interviews with 40 administrators from 16 park and recreation agencies. Interviews contained standardized open-ended questions followed by unstructured probing by the interviewer. Interviews were tape recorded and then transcribed. The author was able to determine types of linkage (ranging from informal linkage, involving minimal cooperation, to formal regularized linkage, involving mutual coordination), effects of linkage participation (e.g., additional use of parks), functions of linkage (e.g., expanding access to facilities and programs), negative consequences of linkage (e.g., channeling groups of people with disabilities into less used park areas), and barriers to and means of facilitating linkage (e.g., defensive reactions to protect organizational autonomy may be resolved through a linkage initiated through interpersonal contact.

Data Analysis

As noted, data collection and analysis (ideally) occur simultaneously in interpretive research. According to Strauss (1987), this is done through a dual process of *coding* and *memoing*. Coding serves to *fracture data* so that conceptualization is possible. This entails identifying and naming categories of behaviors which are relevant within a given setting (cf. Spradley, 1979). In the context of the data, the category is treated as an emergent or grounded concept. Specific behavioral acts, then, are used as indicators of the concept. Central to this process is the identification of one or multiple core categories (Strauss, 1987). For example, in a hypothetical study of leisure behavior in a street gang, a core category could be *demonstration of bravery*. *Shop-lifting* and *playing chicken* might be indicators of the

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Memoing serves a number of functions.[4] First, memoing serves as a record of the analytic process of data collection. Memos of this sort may include reflective notes, such as successful or unsuccessful research strategies. Second, memoing provides a basis for drawing together categories of behavior into emerging theory. In this case, memos are hunches or hypotheses which explicate the nature of relationships among emerging concepts. Finally, memoing provides a basis for theoretical sampling. This type of memo provides concrete instructions as to which cases (e.g., informants) to subsequently sample. The basis for such decisions follow directly from the second type of memo. That is, emerging theory leads to purposeful sampling of cases in order to further elucidate how grounded concepts are related to one another.

Coding and memoing facilitate data reduction. Coding and memoing also serve to enhance internal validity by grounding theory in informants' actions, and the contexts and settings in which behavior is observed.

Data display is then facilitated through presentation of resulting data as well as the procedural and analytic methods that produced the data. Presentation of data is frequently supplemented by excerpts of dialogue from informants and diagrams. Excerpts of dialogue serve as indicators of chosen aspects of data, while diagrams are utilized to indicate the organization of a number of concepts. The presentation of data and methods by which data was derived facilitates replication of a particular study. Through replication of studies, reliability can be addressed (LeCompte & Goetz, 1982).

Strengths and Weaknesses of Interpretive Research

The principle advantage of interpretive research strategies is that they provide in-depth knowledge and understanding of a particular setting or social world. The in-depth nature of interpretive research approaches tends to make for findings that score high in terms of internal validity (LeCompte & Goetz, 1982). A second advantage of qualitative research approaches is that they bring to light important variables that might otherwise be overlooked with a more controlled research strategy. This point was well stated by Whyte (1955) in his study of street corner life: "As I sat and listened, I learned the answers to questions that I would not even have had

the sense to ask if I had been getting my information solely on an interviewing basis" (p. 303). Third, interpretive research strategies are relatively flexible and inexpensive in terms of equipment (Babbie, 1989). The principle disadvantage of interpretive research studies is that they are frequently not generalizable to other settings. Such studies are often criticized because they are weak in terms of external validity. A second disadvantage of interpretive research strategies is that matters pertaining to reliability are not readily controlled. Unlike normative research strategies, standardized concepts are ordinarily not used in interpretive research. Furthermore, the research process tends to be highly individualistic. Hence a common criticism of interpretive research is that findings are biased by observer effects and idiosyncratic judgements on the part of the researcher. [See LeCompte & Goetz (1982) for a thorough discussion of matters pertaining to reliability and validity in interpretive research.] Finally, interpretive research studies tend to be costly in terms of time, and they require a flexible and uncontrolled approach to pursuing research that both experienced and inexperienced researchers may find intimidating.

Conclusion

The purpose of this paper was to present five research methods (experimental methods, single-subject method, survey method, participant observation, and unstructured interviewing) that therapeutic recreation professionals might find suitable in answering research questions. Each of these approaches was described in terms of matters pertaining to sampling, data collection, and data analysis. As noted in our previous paper, we advocate an eclectic approach to pursuing systematic research. Therefore, the five research approaches are presented with the belief that each is best suited to answering distinct research questions. In general, experimental methods, single-subject methods, and survey methods are appropriate research strategies for answering research questions grounded in a normative paradigm. Participant observation and in-depth interviewing are more appropriate for answering questions grounded in an interpretive paradigm.

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Footnotes

1. A number of writers have noted that normative paradigms are closely associated with quantitative research, while interpretive paradigms are associated with qualitative research. This tends to be a misleading generalization since quantitative data (data which is numerical) and qualitative data (data which is descriptive) tend to be generated by a myriad of research methods. For example, experimental research may draw upon voice or video recordings which represents qualitative data. Similarly, in-depth interviewing may result in the quantification of verbal responses to various topics thereby providing a basis for quantitative analysis.

2. The discussion of data collection includes a treatment of the role of internal validity, external validity, and reliability. Internal validity basically deals with the authenticity of results. That is, findings are examined in terms of whether the methods actually measured what they purportedly intended. External validity pertains to the generalizability of findings. In this case, findings are evaluated in terms what groups, situations, and people the research findings may be said to apply. Finally, reliability deals with the replicability of findings. Generally speaking, reliability is determined by evaluating whether research instruments yield consistent findings across time and across different situations.

3. There are two broad categories of sampling methods: probability sampling and purposive sampling. A probability sample is one in which people within a population have an equal chance of being represented. Examples of probability samples include simple random samples and stratified random samples. A purposive sample is one in which people within a population have an unequal chance of being represented. A purposive sample is often used when all cases within a population cannot be identified.

4. For a more complete description of memoing, the reader may wish to examine Strauss' (1987) treatment of the subject.

Standards: A Tool for Accountability The CARF Process

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Abstract

This article provides a brief rationale and history of the development of quality assurance standards within the TR discipline as they relate specifically to CARF. A review of the chronology of standards development is pursued along with a call for more TR practitioners to became actively involved in the process. Without clear standards to measure the quality of treatment results TR will not be able to keep pace until the rapidly expanding national health care system.

Introduction

Health-care is advancing at an incredibly rapid pace; with this comes the demand for the provider to be professionally accountable and to provide cost effective services. A tool for determining the quality of the services provided is via the implementation of standards, or predetermined elements against which the treatment can be compared (Riley, 1987).

The profession of Therapeutic Recreation is guided by one set of nationally recognized competency standards for qualified personnel. This is the examination process that has been established by the National Council for Therapeutic Recreation Certification (NCTRC), and overseen by the Educational Testing Service (NCTRC, 1990).

The Therapeutic Recreation profession also has *Guidelines For The Administration of Therapeutic Recreation Services* (NTRS, 1990). The latter provides some basic parameters to utilize when implementing Therapeutic Recreation programs in various practice settings; e.g. philosophy/goals, scope of service, personnel practices, evaluation and consumer involvement. The tools that are currently available within the area of professional expertise serve as a within discipline benchmarks.

However, certified TR specialists are now part of a much larger arena; the health-care industry. Therapeutic recreation must become attuned to the external accrediting bodies, that shape and pay for health-care services. As an interdisciplinary team member the CTRS will be required to adhere to industry and consumer driven standards in an effort to keep pace, be accountable and cost effective.

C.A.R.F.

A major non-governmental body that establishes standards for organizations providing rehabilitation services is the Commission on Accreditation of Rehabilitation Facilities (C.A.R.F.). C.A.R.F. was formed in 1966 when the Association of Rehabilitation Centers (A.R.C.) and the National Association of Sheltered Workshops and Homebound Programs (N.A.S.W.H.P.) agreed to pool their interests in standards. The consolidation resulted in the formation of the Commission.

The CARF Commission, based in Chicago, Illinois, entered into an administrative relationship with the Joint Commission on Accreditation of Hospitals (J.C.A.H.), which provided the needed expertise in the area of accreditation (CARF 1990). JCAH and CARF continued this agreement until 1971

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when they became separate entities establishing different missions, goals and objectives for their respective organizations.

In the years since its formation, the Commission has steadily and dramatically grown in size and stature. Currently, there are over 2800 accredited organizations. In addition, numerous entities - both governmental and private - have adopted expectations, requirements, and/or endorsements of accreditation by the Commission for organizations serving people with disabilities.

The Standards Process

Why were standards developed? Initially standards for rehabilitation services did not exist, thus at a systems level organizations could not be held accountable for the quality of services rendered. Neither method to reassure consumers or purchasers of the effectiveness and efficiency of programs nor common definitions in the field of rehabilitation existed. Over the years, the Commission has served as a vehicle to define and hold organizations accountable for service outcomes.

Regarding the development of standards themselves, three processes set CARF's approach apart from other accrediting bodies: 1) the field based approach to standards development; 2) the survey process which utilizes independent peer review; 3) and the focus on program evaluation which measures program outcome.

Field Based Approach

Since it's inception, the Commission has utilized practicing clinicians to develop standards through the convening of National Advisory Committees. Clinicians, consumers, and third party payer representatives, who are nationally recognized leaders with expertise in a particular program area, are brought together to develop consensual standards which reflect current practices in the field. By example, the profession of therapeutic recreation was represented by Joanne Finegan, CTRS in January of 1991. That National Advisory Committee was charged by the Commission to review Section 2.1 - Overall Program Standards and the specific standards for Brain Injury Programs, Acute and Post Acute, in Section 2.11.

Recommendations developed by these National Advisory Committees are then sent out for field review to 2000-5000 recipients, including providers, consumers, professionals, and organizations involved in the field of rehabilitation. As an advocate for the Therapeutic Recreation profession, any CTRS can take an active role in supporting revisions of these proposed standards. All CARF accredited organizations, supporting members, associate members, surveyors, and interested professional organizations, can receive the proposed standard revisions and submit comments.

Following the field review process, comments regarding the proposed standards are compiled and reviewed in the CARF office. Standards are submitted to the standards committee of the Commission's Board of Trustees and must be accepted by the entire Board of Trustees prior to inclusion in the Standards Manual.

Survey Process

Practicing clinicians participate in a peer review process to provide on-site surveys of rehabilitation organizations. Surveyors are selected for site surveys based on the experience and expertise which best matches the organization's programs. The first Certified Therapeutic Recreation Specialist to be trained as a surveyor, outside of CARF professional staff, was Christine Lay, CTRS. Administrative and program surveyors must do a comprehensive review of an organization to determine if the organization is in compliance with the standards for which they are being reviewed. Organizational records such as: fiscal reports, safety reports, case records, and administrative records are reviewed in the survey process. Staff members and consumers are interviewed and program manuals and evaluation systems are also examined (CARF, 1991).

Outcome Oriented Evaluation

Recent trends in health-care oriented systems call for establishment of an outcome review program. This system requires the articulation of the organizations role and commitment toward continuous improvement of patient/client services. The Commission and the American Therapeutic Recreation Association (ATRA) are committed to the review of program outcomes through program evaluation. CARF was the first accrediting body to

focus on specified program outcomes as a means to evaluate success. In the early 1970s, the field of rehabilitation began to articulate the need for measurement of treatment results. Global questions like, "Did the lives of people significantly improve as a result of participation in rehabilitation programs?" went largely unanswered. There was a sense of frustration among professionals with what was seen as preoccupation by providers, purchasers, and consumers with the input and process aspects of the rehabilitation system. If program evaluation systems were to become part of the human service network, these systems should meet standards of quality like any other element of the delivery system. In November 1973, the Commission published a new section of the Standards Manual specifically identifying program evaluation standards. The program evaluation system is designed to generate continuous reports that delineate the accomplishments of the persons served. The program reports are then utilized by the interdisciplinary team members, (who provide goal directed services), to maintain and/or improve program performance.

CARF's Core Team

The Commission identifies the make-up and functions of the interdisciplinary team in its role as the primary decision-making body regarding provision of services to persons with disabilities. Where the industry has evolved and certification or standards of practice have been established, CARF has incorporated these requirements into the Glossary section of the Standards Manual. In 1983, the Standards Manual included a definition for therapeutic recreation. In this manual Therapeutic Recreation is defined as services provided by someone who currently meets applicable legal requirements, and/or who is certified or eligible for certification by the N.C.T.R.C. as a Therapeutic Recreation Specialist. The inclusion of definitions, qualifications and licensing/certification requirements in the CARF manual glossary serves to legitimize the role of the TR profession as part of the Core team and reinforces our position as professional providers of care within in the treatment milieu.

Conclusion

The Commission has developed an impartial and objective means of evaluating accountability. Accreditation becomes a tool to identify programs that can substantiate their claims of success. This is important in an era of competition and limited dollar resources. Previously, there was no certifying or licensing body for program areas. The role of the Commission is to impact upon the quality of care provided by organizations. To that end program standards have been developed which substantiate the organization's adherence to national standards.

Certified Therapeutic Recreation Specialists must interface their professional competency with the larger rehabilitation arena. Interfacing with CARF and similar organizations allows for greater monitoring of standards that impact on patient care, organizational performance, and management effectiveness. The profession of TR must continue to provide external and internal feedback to CARF thus demonstrating our professional commitment to the continuous improvement of quality of care. ATRA has moved to ensure such representation for its membership by achieving Associate Sponsor status with CARF, since December of 1988.

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Editors' Note

In the Fall of 1990, the *Annual's* advisory board, in conjunction with the editors, agreed to expand the editorial mission. Each year the advisory board may decide to issue invitations for manuscripts on select topics deemed particularly relevant or timely to the practice of therapeutic recreation. In this regard such *invited* works ensure that coverage of critical or key issues will appear and not be dependent upon the random or chance factors of an open call. These invited works, while undergoing editorial scrutiny, are not subject to the same blind review process as open call manuscripts. The advisory board, alone, has final authority in the publication decision of invited manuscripts.

For the readers' benefit, editors of the *Annual* will always note invited manuscripts as such. The above article represents the inaugural manuscript of this editorial feature. Readers of the *Annual* who have suggestions or comment regarding invited works are encouraged to write directly to: Editors, *Annual in Therapeutic Recreation*, c/o AALR, 1900 Association Drive, Reston, VA 22091.

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-- To encourage and facilitate dissemination of research which will enrich the depth and scope of the practice of therapeutic recreation.

-- To stimulate continuous development in practice and research standards.

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